

13061

CERTIFICATE OF DEATH

13057

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>12</b>			
d. NAME OF HOSPITAL (If not in hospital, give street-address) OR INSTITUTION <b>Pen Gen Hospital</b>				e. STREET ADDRESS <b>413 Martin St</b>			
3. NAME OF DECEASED (Type or print) First <b>ATWOOD</b> Middle <b>BEDSWORTH</b> Last <b>BEDSWORTH</b>				4. DATE OF DEATH Month <b>NOV.</b> Day <b>24th</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>Single</b>	8. DATE OF BIRTH <b>Sept. 29, 1903</b>	9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months <b>55</b> Days <b>55</b> Hours <b>55</b> Min.	IF UNDER 24 HRS. Months <b>55</b> Days <b>55</b> Hours <b>55</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George H. Bedsworth</b>				14. MOTHER'S MAIDEN NAME <b>Sallie Windsor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. #2</b>		17. INFORMANT <b>Mrs. Pearl Bolen (Sister) P.O.B. # 194 Fruitland, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Bronchitis-pulmonary infarction</b> DUE TO <b>Adema of lungs, Bronchitis, tubes, and to acute Bronchitis-pulmonary infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adema of lungs, Bronchitis, tubes, and to acute Bronchitis-pulmonary infarction</b> DUE TO (c) <b>Adema of lungs, Bronchitis, tubes, and to acute Bronchitis-pulmonary infarction</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/24/58</b> , 19 <b>58</b> , to <b>11/24/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/24/58</b> , 19 <b>58</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Carrie I. Hearn</b>				DATE SIGNED <b>Nov. 25/1958</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Carrie I. Hearn</b>				ADDRESS (Street, city or town, state) <b>226 N. Division St. Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 27, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oriole Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oriole, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>NOV 26 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hearn</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

FILE NO.

NAME	AGE	SEX	RACE	DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH	CAUSE OF DEATH	DIAGNOSIS	DATE OF EXAMINATION	SIGNATURE

*Handwritten text, likely a signature or note, appearing upside down.*

62-11111

11/24/11

11/24/11

*Handwritten text, likely a signature or note.*

*Handwritten text, likely a signature or note.*

DATE OF EXAMINATION	SIGNATURE

131116

CERTIFICATE OF DEATH

13058

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hebron</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hebron Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Marvin A. Birkhead</u>				4. DATE OF DEATH <u>11 7 1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/24/ 1890</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Noah Birkhead</u>				14. MOTHER'S MAIDEN NAME <u>Marry E. West</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sarah M. Birkhead</u> Address <u>Hebron MD. box 372</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, essential</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. [City or town] (County) (State)			
21. I certify that I attended the deceased from <u>1956</u> to <u>Nov 7th</u> , 1958, that I last saw the deceased alive on <u>November 1st</u> , 1958, and that death occurred at <u>6:34</u> A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. V. Sohler</u> M.D.				ADDRESS (Street, city or town, state) <u>303 East Street Delmar Md.</u> DATE SIGNED <u>11-8-58</u>			
PHYSICIAN'S NAME (Type) <u>L. V. Sohler</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/13/ 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>green acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton E. Stewart</u> ADDRESS <u>Salisbury Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 11 7 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED                  [Faint handwritten name]</p>		<p>DATE OF DEATH                  [Faint handwritten date]</p>	
<p>AGE                  [Faint handwritten age]</p>		<p>SEX                  [Faint handwritten sex]</p>	
<p>PLACE OF BIRTH                  [Faint handwritten place]</p>		<p>DATE OF BIRTH                  [Faint handwritten date]</p>	
<p>CAUSE OF DEATH                  [Faint handwritten cause]</p>		<p>PLACE OF DEATH                  [Faint handwritten place]</p>	
<p>DATE OF INTERMENT                  [Faint handwritten date]</p>		<p>PLACE OF INTERMENT                  [Faint handwritten place]</p>	
<p>NAME OF FUNERAL HOME                  [Faint handwritten name]</p>		<p>NAME OF MINISTER                  [Faint handwritten name]</p>	
<p>NAME OF CLERGYMAN                  [Faint handwritten name]</p>		<p>NAME OF CHURCH                  [Faint handwritten name]</p>	
<p>NAME OF BURIAL PLACE                  [Faint handwritten name]</p>		<p>NAME OF CEMETERY                  [Faint handwritten name]</p>	
<p>NAME OF CITY                  [Faint handwritten city]</p>		<p>NAME OF COUNTY                  [Faint handwritten county]</p>	
<p>NAME OF STATE                  [Faint handwritten state]</p>		<p>NAME OF COUNTRY                  [Faint handwritten country]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13062

CERTIFICATE OF DEATH

Reg. Dist. No. 13059

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>147 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>14x-2</b>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Bond</b> Last <b>Bond</b>				4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 21, 1897</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>61</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm laborer</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm work</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unk.</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Johnson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>WW 1</b>		16. SOCIAL SECURITY NO. <b>222-12-4309</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General arteriosclerosis</b> DUE TO (c) <b>Yrs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Varicose ulcer of left leg; secondary anemia.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> Month <b>11</b> Day <b>20</b> Year <b>1958</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 26, 1958</b> , to <b>Nov. 20, 1958</b> , that I last saw the deceased alive on <b>Nov. 20, 1958</b> , and that death occurred at <b>7:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>11/20/58</b>							
ACTUAL SIGNATURE <b>G. Kosmahly</b>		M.D. <b>Deer's Head State Hospital</b> <b>11/20/58</b>					
PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M. D.</b>		<b>Salisbury, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 23, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pomona</b>		22d. LOCATION (City, town, or county) (State) <b>near Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth Walcott</b>				ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 25 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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13063

CERTIFICATE OF DEATH

13060

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Sharptown MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Locust Street</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy <del>Attie</del></u> First Middle Last		4. DATE OF DEATH <u>November 28 1958</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/27/1958</u>
9. AGE (In years last birthday) yrs. <u>11</u> Months <u>28</u> Days <u>28</u> Hours <u>19</u> Min. <u>58</u>		10. AGE (In years last birthday) yrs. <u>11</u> Months <u>28</u> Days <u>28</u> Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Walter Brown</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Morris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Walter Brown Sharptown Maryland</u>	
17. INFORMANT <u>Walter Brown Sharptown Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atelectasis, fetal type</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/28</u> 19 <u>58</u> to <u>11/28</u> 19 <u>58</u> that I last saw the deceased alive on <u>11/28</u> 19 <u>58</u> and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>R. W. Saunderson, Jr.</u> M.D.		702 Camden Avenue	
PHYSICIAN'S NAME (Type) <u>R. W. Saunderson, Jr., M. D.</u>		Salisbury, Maryland 12/3/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/2/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sharptown</u>		22d. LOCATION (City, town, or county) (State) <u>Sharptown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u> ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 5 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2082162XVO

CERTIFICATE OF DEATH

Warrant

RETURNED TO SENDER

CONFIDENTIAL

RECEIVED

NOV 19 1950

U.S. DEPT. OF JUSTICE

WASHINGTON, D.C.

RECEIVED

NOV 19 1950

U.S. DEPT. OF JUSTICE

WASHINGTON, D.C.

RECEIVED

NOV 19 1950

U.S. DEPT. OF JUSTICE

WASHINGTON, D.C.

RECEIVED

NOV 19 1950

U.S. DEPT. OF JUSTICE

WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13117

## CERTIFICATE OF DEATH

Reg. Dist. No.

13061

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela Springs</b>		c. LENGTH OF STAY IN 1b <b>71 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD # 1</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela Springs, Md.</b>	
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <b>RFD # 1</b>	
3. NAME OF DECEASED (Type or print) First <b>Sherman</b> Middle <b>Edward</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>8,</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1887</b>
9. AGE (In years last birthday) <b>71 yrs.</b>		IF UNDER 1 YEAR: Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min. <b>71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Daniel Brown</b>		14. MOTHER'S MAIDEN NAME <b>Mary Virginia Molock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-16-7398</b>	
17. INFORMANT <b>Bessie Brown, Mardela Springs, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis (Coronary)</b> <b>610X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Nephrosis</b> DUE TO (c) <b>Prostatic Hypertrophy</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b> <b>14 yrs.</b> <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 1</b> , 19 <b>58</b> , to <b>Nov 8</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Nov 8</b> , 19 <b>58</b> , and that death occurred at <b>11:01</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. S. Kuhlman</b>		DATE SIGNED <b>11/10/58</b>	
PHYSICIAN'S NAME (Type) <b>H. S. Kuhlman</b>		ADDRESS (Street, city or town, state) <b>Shelton Rd</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-12-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Zion</b>		22d. LOCATION (City, town, or county) (State) <b>Mardela Springs, Md. RFD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles W. Spaulding</b>		24. REC'D BY REGISTRAR <b>NOV 13 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thrane</b>			



CERTIFICATE OF DEATH

13062

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>618 S.Division St</b>		d STREET ADDRESS <b>618 S.Division St.</b>	
3 NAME OF DECEASED (Type or print) <b>IDA</b> First <b>E</b> Middle <b>CANNON</b> Last		4. DATE OF DEATH <b>NOV.</b> Month <b>9th</b> Day <b>19 58</b> Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 20, 1893</b>
9. AGE (In years last birthday) <b>65</b> yrs		10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work at Home</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Pusey</b>		14 MOTHER'S MAIDEN NAME <b>Annie E. Quillin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Lemuel M. Cannon (Husband)</b> Address <b>618 S.Div.St. Salisbury, Maryland</b>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b> <b>44<sup>2</sup> X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio Vascular Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10-12</b> , 19 <b>53</b> to <b>11-8</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/8/58</b> , 19 <b>58</b> , and that death occurred at <b>3:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>AC Mitchell</b>		ADDRESS (Street, city or town, state) <b>211 Maryland Ave</b> DATE SIGNED <b>Nov. 10 / 1958</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Andrew C. Mitchell</b>		<b>Maryland Ave. Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)
<b>Burial</b>	<b>Nov. 11, 1958</b>	<b>Parsons Cemetery</b>	<b>Salisbury, Maryland</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>		24a REC'D BY REGISTRAR <b>NOV 12 58</b> DATE 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13065

## CERTIFICATE OF DEATH

13063

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>3 yrs 1 mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Jennie</b> Middle <b>Lee</b> Last <b>Carroll</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>4</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/5/1867</b>	
9. AGE (In years last birthday) <b>91</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>?</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John Merrick</b>				14. MOTHER'S MAIDEN NAME <b>Louise LeCompte</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>							
420.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerosis, general</b>							
DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>October 6, 1955</b> , to <b>November 4, 1958</b> , that I last saw the deceased alive on <b>November 3, 1958</b> , and that death occurred at <b>6:15 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. V. Maldve</b>				DATE SIGNED <b>11/4/58</b>			
PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>				ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Nov 10</b>		<b>Nov 10</b>		<b>East New Market</b>		<b>East New Market, Md</b>	
23. FEDERAL DIRECTOR'S SIGNATURE <b>J. H. Willoughby</b>				24a. REC'D BY REGISTRAR <b>NOV 7</b>			
24b. REGISTRAR'S SIGNATURE							

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1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

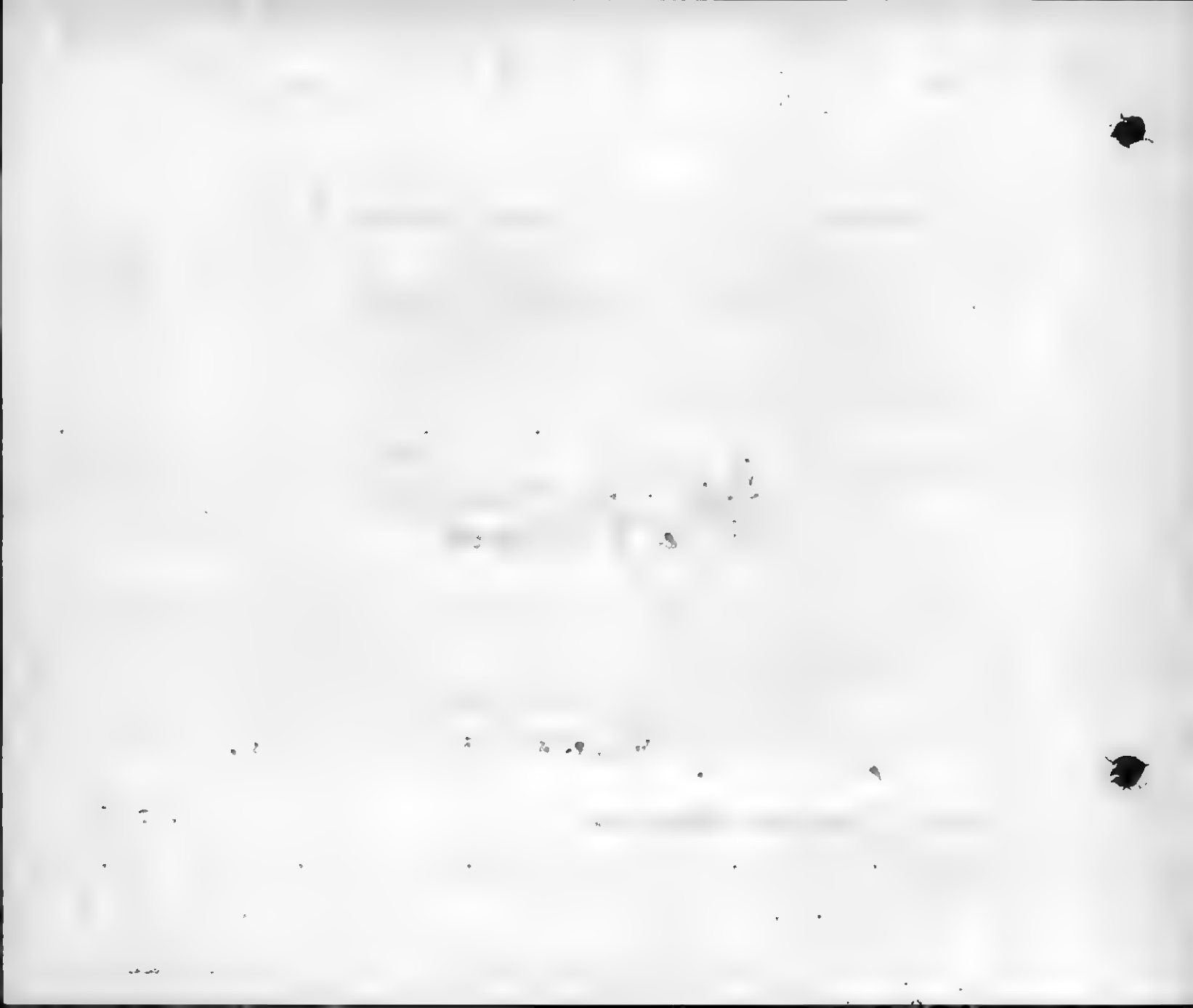
13066

13064

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury (Rural) 310 E. Vine St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>310 E. Vine St.</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>-</u> Last <u>Cecil</u>		4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30-1877</u>
9. AGE (In years last birthday) <u>81</u> yrs		IF UNDER 1 YEAR: Months <u>1</u> Days <u>22</u> Hours <u>-</u> Min <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. H.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. H.</u>	
13. FATHER'S NAME <u>John Grayson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Summies</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Mr. Louis H. Stevens-6116 18th Road N. Arlington Virginia</u>	
17. INFORMANT <u>Mr. Louis H. Stevens-6116 18th Road N. Arlington Virginia</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe, sudden hemorrhage from cancer of stomach</u> DUE TO (b) <u>cancer of stomach</u> DUE TO (c) <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 23, 1958</u> to <u>Nov 23, 1958</u> that I last saw the deceased alive on <u>Nov 23, 1958</u> , and that death occurred at <u>8:25</u> M., from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Nov. 25th/1958</u>			
ACTUAL SIGNATURE <u>Carrie I. Hearn</u> M.D.		DATE SIGNED <u>Nov. 25th/1958</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Carrie I. Hearn</u>		<u>226 N. Division St. Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 26, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLIOWAY &amp; COMPANY</u>		24a. REC'D BY REGISTRAR <u>NOV 26 '58</u>	
ADDRESS <u>SALISBURY MARYLAND</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13118

## CERTIFICATE OF DEATH

Reg. Dist. No. 13665

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 1 Salisbury Route</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b>	
f. STREET ADDRESS <b>R.D.# 1 Salisbury Route</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>SILAS</b> Middle <b>WILSON</b> Last <b>CHAPMAN</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>26th</b> Year <b>19 58</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 27, 1873</b>
9. AGE (In years last birthday) <b>85</b>		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>29</b>	11. IF UNDER 24 HRS Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee of Wood-Working Co. (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>	
11. BIRTHPLACE (State or foreign country) <b>Stockton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William K. Chapman</b>		14. MOTHER'S MAIDEN NAME <b>Mary E.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b></b>	
17. INFORMANT <b>Mrs. Bettye M. Chapman (Wife)</b>		Address <b>R.D.#1 Sal. Md. Fruitland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Ascending Colon</b> <b>105.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August</b> , 19 <b>58</b> , to <b>Sept</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Sept. 17, 1958</b> , and that death occurred at <b>6:30 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Pine Bluff Rd. Salisbury, Md.</b> DATE SIGNED <b>Nov. 28 /1958</b>			
ACTUAL SIGNATURE <b>Thomas C. Hill</b> M.D.		DATE SIGNED <b>Nov. 28 /1958</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Thomas C. Hill</b>		ADDRESS <b>Pine Bluff Rd. Salisbury, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>Nov. 30, 1958</b>	<b>Parsons Cemetery</b>	<b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		24a. REC'D BY REGISTRAR <b>DEC 2 58</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		24b. REGISTRAR'S SIGNATURE <b>Thos. P. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13067

## CERTIFICATE OF DEATH

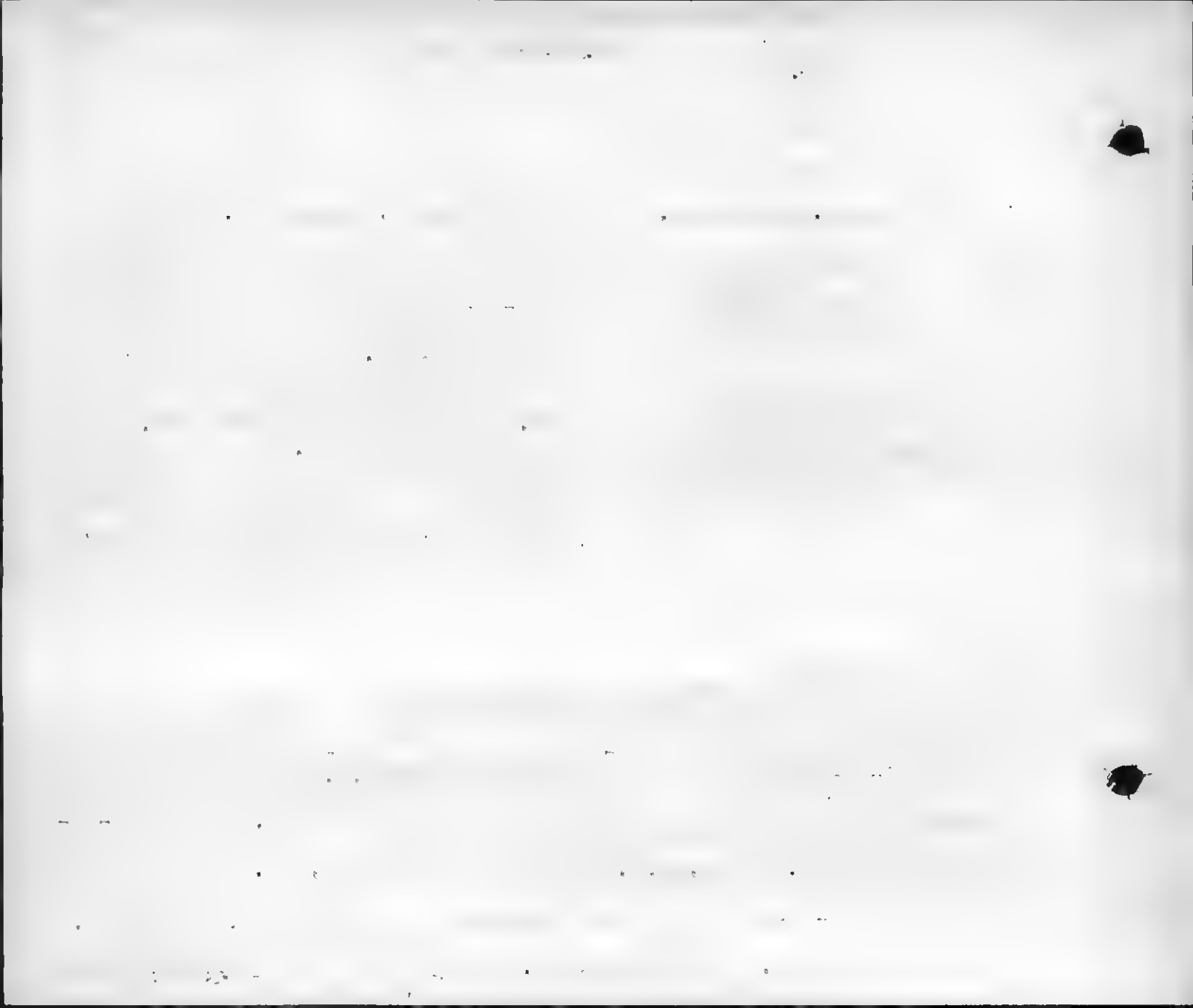
13066

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Res. den. before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>205 1/2 E. Locust St.</u>				d. STREET ADDRESS <u>205 1/2 E. Locust St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>Chatham</u> Last <u></u>				4. DATE OF DEATH Month <u>11</u> Day <u>20</u> Year <u>19 58</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-22-1885</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Allen, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>Elijah Chatham</u>				14. MOTHER'S MAIDEN NAME <u>Arlena Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mrs. Lola Ownens 301 Quincy St. Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-28-58</u> , 19 <u>58</u> , to <u>11-20-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-31-58</u> , 19 <u>58</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>407 Camden Ave.</u> DATE SIGNED <u>11-22-58</u>							
ACTUAL SIGNATURE <u>Earl L. Boyer</u> M.D.				PHYSICIAN'S NAME (Type) <u>Earl L. Boyer, M.D.</u> <u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-24-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Worcester County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway and Co.</u> <u>Salisbury, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton L. Howard</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13068

## CERTIFICATE OF DEATH

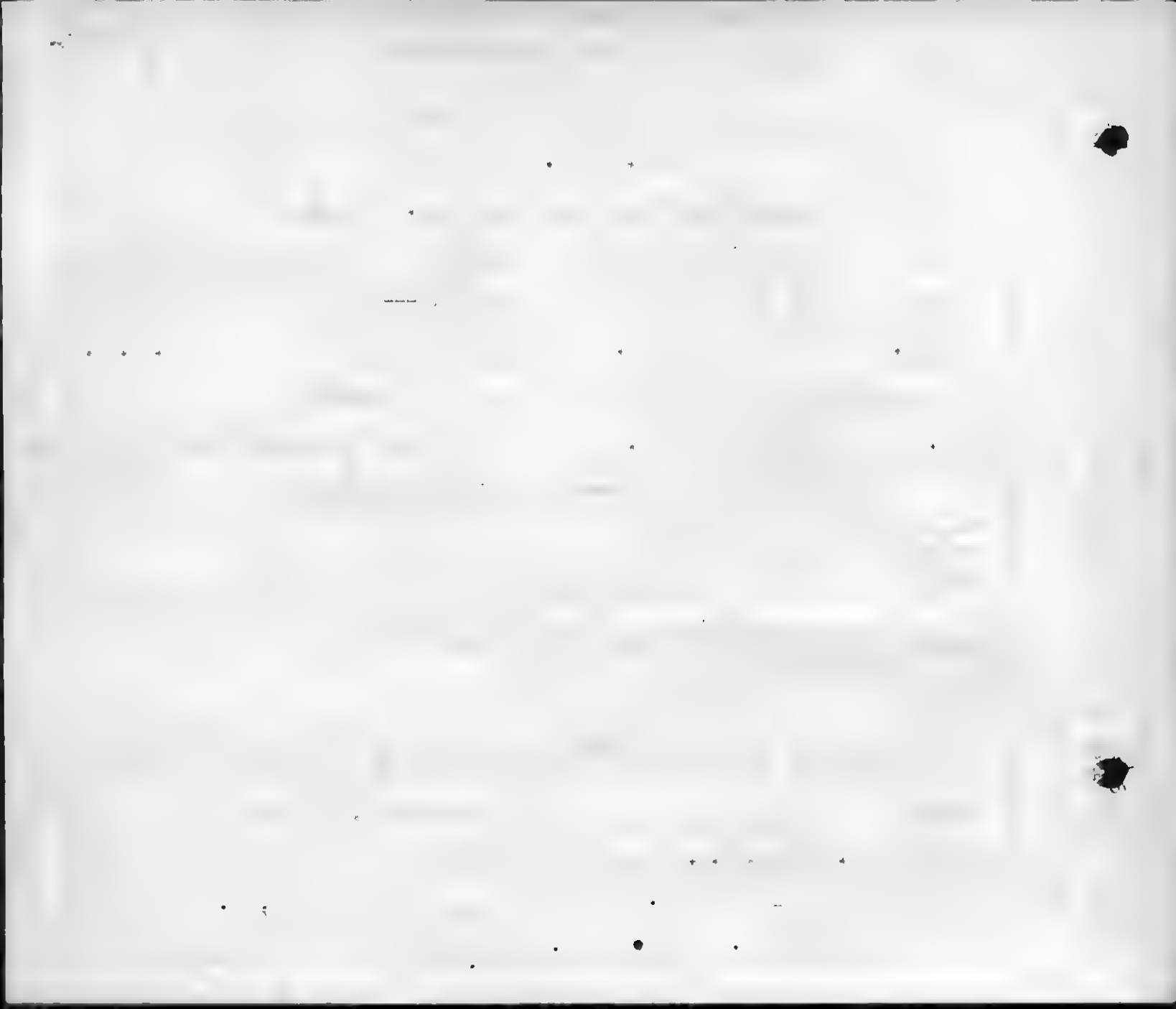
13067

Reg. Dist. No.

1 PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>2 mos. 20 da.</b>		d. STREET ADDRESS <b>609 N. 36th Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Francis</b> Middle <b>Mae</b> Last <b>Chapman</b>		4. DATE OF DEATH Month <b>November</b> Day <b>8</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 31, 1951</b>
9. AGE (In years last birthday) <b>78</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unk.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unk.</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13 FATHER'S NAME <b>Charles Hosley</b>		14. MOTHER'S MAIDEN NAME <b>Fosse</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unk.</b>		16 SOCIAL SECURITY NO. <b>Unk.</b>	
17. INFORMANT <b>Hospital Records - Salisbury, Maryland</b>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <input checked="" type="checkbox"/> <b>Arteriosclerotic Cardiovascular Disease</b> 4-12-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/> <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/19/58</b> , 19 <b>58</b> , to <b>11/8</b> , 19 <b>58</b> ; that I last saw the deceased alive on <b>11/8</b> , 19 <b>58</b> , and that death occurred at <b>6:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>11/8/58</b> ACTUAL SIGNATURE <b>L. Malone, M.D.</b> M.D. <b>Salisbury, Maryland</b> PHYSICIAN'S NAME (Type) <b>L. Malone, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-11-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		22d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>Mr Cook-Townson, Inc. 1050 York Rd. Towson, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 10 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hous</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13069-

## CERTIFICATE OF DEATH

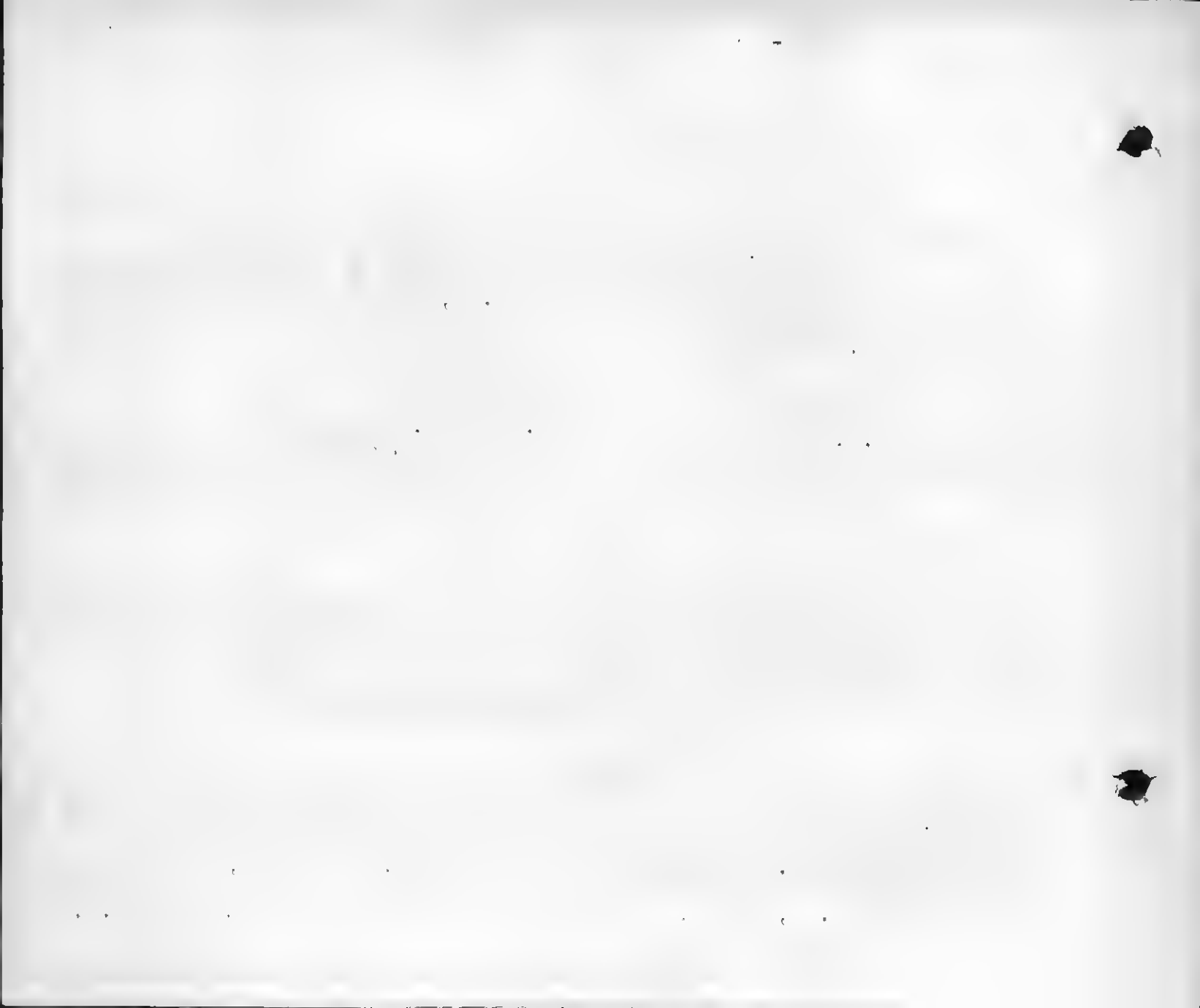
13068

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm ssion) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12. SALISBURY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>IRVING</u> Last <u>COHEN</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11, 1909</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>11</u> Days <u>28</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio Tech. &amp; Repairman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>(Own Business)</u>	
11. BIRTHPLACE (State or foreign country) <u>Oklahoma</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>No Record</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. 11</u>	
17. INFORMANT <u>Mrs. Della S. Cohen (Wife)</u>		Address <u>300 Sheffield Ave Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>7. X Erythema Multiforme</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 19, 57</u> to <u>Nov. 9, 1958</u> , that I last saw the deceased alive on <u>Apr. 9, 1958</u> , and that death occurred at <u>2 A. M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Salisbury Md. Nov. 9, 1958</u> DATE SIGNED			
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.		PHYSICIAN'S NAME (Type) <u>Dr. David J. Gilmore</u> Medical Centre, Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Cremation</u>	<u>Nov. 13, 1958</u>	<u>J. Wm Lee &amp; Son Funeral Home</u>	<u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	24a. REC'D BY REGISTRAR <u>NOV 12 58</u>
		24b. REGISTRAR'S SIGNATURE <u>C. J. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far as use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13119

## CERTIFICATE OF DEATH

13069

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>				c. LENGTH OF STAY IN lb <b>19 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RED # 3</b>				e. STREET ADDRESS <b>Delmar</b> <b>RED # 3</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ralph Thompson Coursey</b>				4. DATE OF DEATH Month Day Year <b>Nov. 15, 1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23, 1892</b>	9. AGE (In years last birthday) <b>66 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Street car</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ralph T. Coursey</b>				14. MOTHER'S MAIDEN NAME <b>Florence Covell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>215-2-2057</b>		17. INFORMANT <b>Beatrice Bratten, Delmar, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <b>3/1, 1957</b> , to <b>death</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/7/58</b> , 19 <b>58</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Carl M. Lamm</b>				ADDRESS (Street, city or town, state) <b>100 Grove St.</b>			
DATE SIGNED <b>11/15/58</b>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>							
22b. DATE THEREOF <b>11-19-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons</b>		22d. LOCATION (City, town, or county) (State) <b>Delmar, Delaware</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. S. Spaul Co. - Delmar, Del</b>				24a. REC'D BY REGISTRAR <b>NOV 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

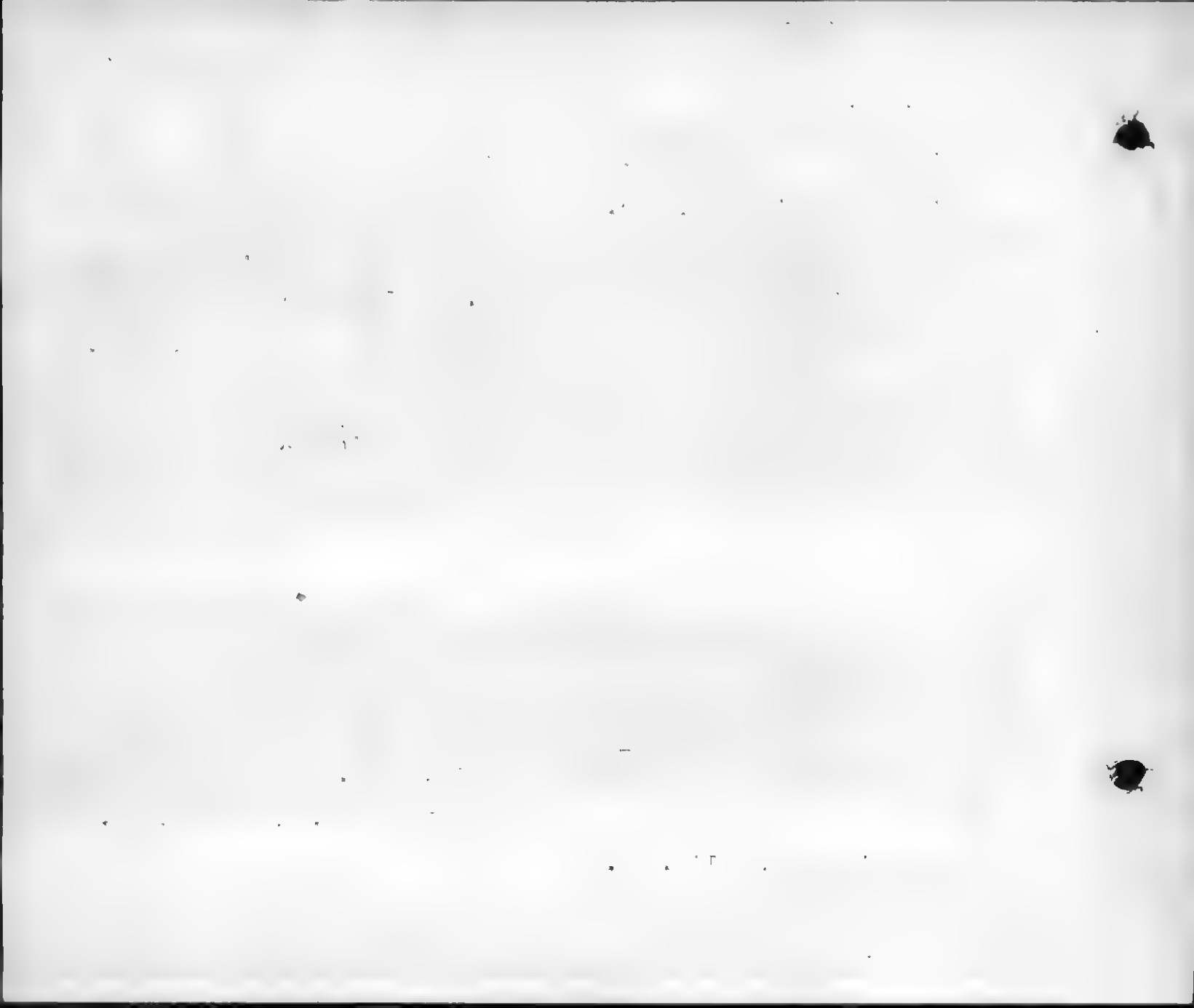


1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13070  
CERTIFICATE OF DEATH

Reg. Dist. No. 13070

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>2 Mo.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springhill Sanitarium, Inc.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ocean City</b>	
3. NAME OF DECEASED (Type or print) First <b>HETTIE</b> Middle <b>Mary</b> Last <b>Cropper</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>30,</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 20, 1880</b>
9. AGE (In years last birthday) <b>78</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>LEONARD R. CROPPER</b>		14. MOTHER'S MAIDEN NAME <b>MARY BOWDEN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>No</b>	
17. INFORMANT <b>MRS. MARGARET KEENE CROPPER, Jr.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarct, acute</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-5-</b> <b>1958</b> , to <b>11-30</b> , <b>1958</b> , that I last saw the deceased alive on <b>11-29</b> , <b>1958</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Medical Center, Salisbury, Md.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Wilber R. Ellis, Jr.</b> M.D. <b>Medical Center, Salisbury, Md.</b>			
NAME (Type) <b>Wilber R. Ellis, Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<b>Burial</b>		<b>12/3/58</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Evergreen Co.</b>		<b>Salisbury, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert R. DeBoys</b>		24a. REC'D BY REGISTRAR <b>DEC 3 '58</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>	



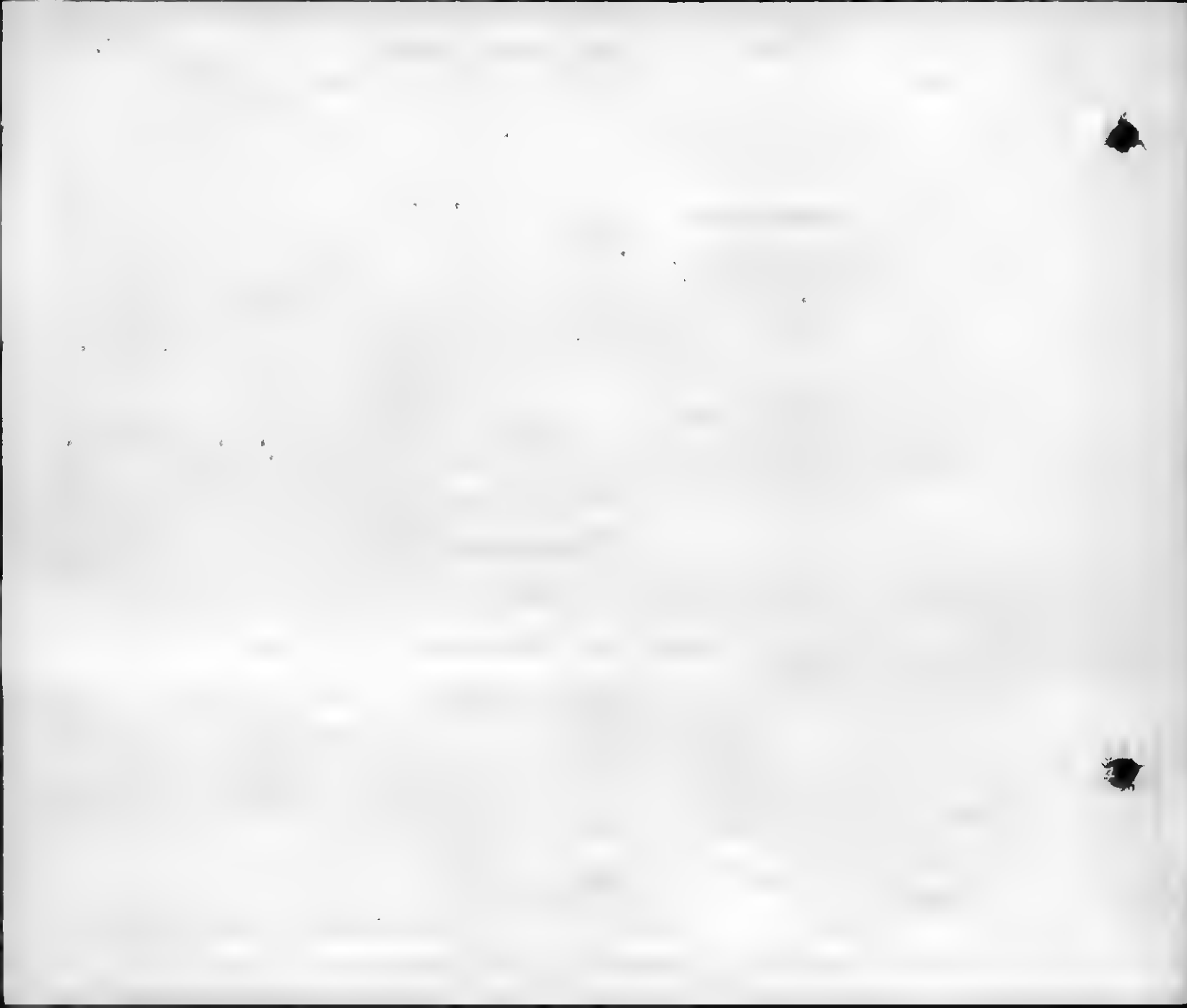
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13120**  
**CERTIFICATE OF DEATH**

13071

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Quantico R.F. D. 3</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>				e. STREET ADDRESS <b>R. F. D. # 3</b>			
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>F.</b> Last <b>Dashield</b>				4. DATE OF DEATH Month <b>11</b> Day <b>8</b> Year <b>1958</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/27/1899</b>		9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frank Dashield</b>				14. MOTHER'S MAIDEN NAME <b>Angia Gosslee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>Margrette Dashield R.F. D. 3 Hebron Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>?</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>Unknown</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 8, 1958</b> to <b>Nov. 8, 1958</b> that I last saw the deceased alive on <b>Nov. 8, 1958</b> , and that death occurred at <b>9:30</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>400 E. Church St. Salisbury Md.</b> DATE SIGNED <b>Nov 15, 58</b>							
ACTUAL SIGNATURE <b>G. Herbert Sembly</b> M.D.				PHYSICIAN'S NAME (Type) <b>G. Herbert Sembly</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>11/16/ 58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Quantico</b>		22d. LOCATION (City, town, or county) (State) <b>Quantico Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clinton S. St. John</b>				ADDRESS <b>Salisbury Md.</b>		24a. REC'D BY REGISTRAR <b>DAKOV 20 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>John S. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13121

## CERTIFICATE OF DEATH

13072

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Thames</i>		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission a. STATE <i>Md</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Madella</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Madella</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Harold</i> First <i>Harold</i> Middle <i>James</i> Last <i>Harold</i>		4. DATE OF DEATH Month <i>Nov</i> Day <i>5</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 1885</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	9. AGE (In years last birthday) <i>73</i> yrs
11. BIRTHPLACE (State or foreign country) <i>Madella</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Frank L. L. L.</i>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>19-07-7157</i>	17. INFORMANT <i>Harold L. L.</i> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO <i>Degenerative Heart Disease</i> (b) <i>Arteriosclerosis</i> (c) <i>Indefinite</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>1 yr 4 mo</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>15 June</i> , 19 <i>58</i> , to <i>5 Nov</i> , 19 <i>58</i> that I last saw the deceased alive on <i>5 Nov</i> , 19 <i>58</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Harold</i>		ADDRESS (Street: city or town, state) DATE SIGNED <i>7 Nov 58</i>	
PHYSICIAN'S NAME (Type) <i>E. A. PURNELL, M.D.</i>		ADDRESS <i>Salisbury, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>11-9-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Madella</i>	22d. LOCATION (City, town, or county) (State) <i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harold</i> ADDRESS		24a. REC'D BY REGISTRAR DATE <i>NOV 13 58</i>	24b. REGISTRAR'S SIGNATURE <i>John E. Frank</i>



13071

CERTIFICATE OF DEATH

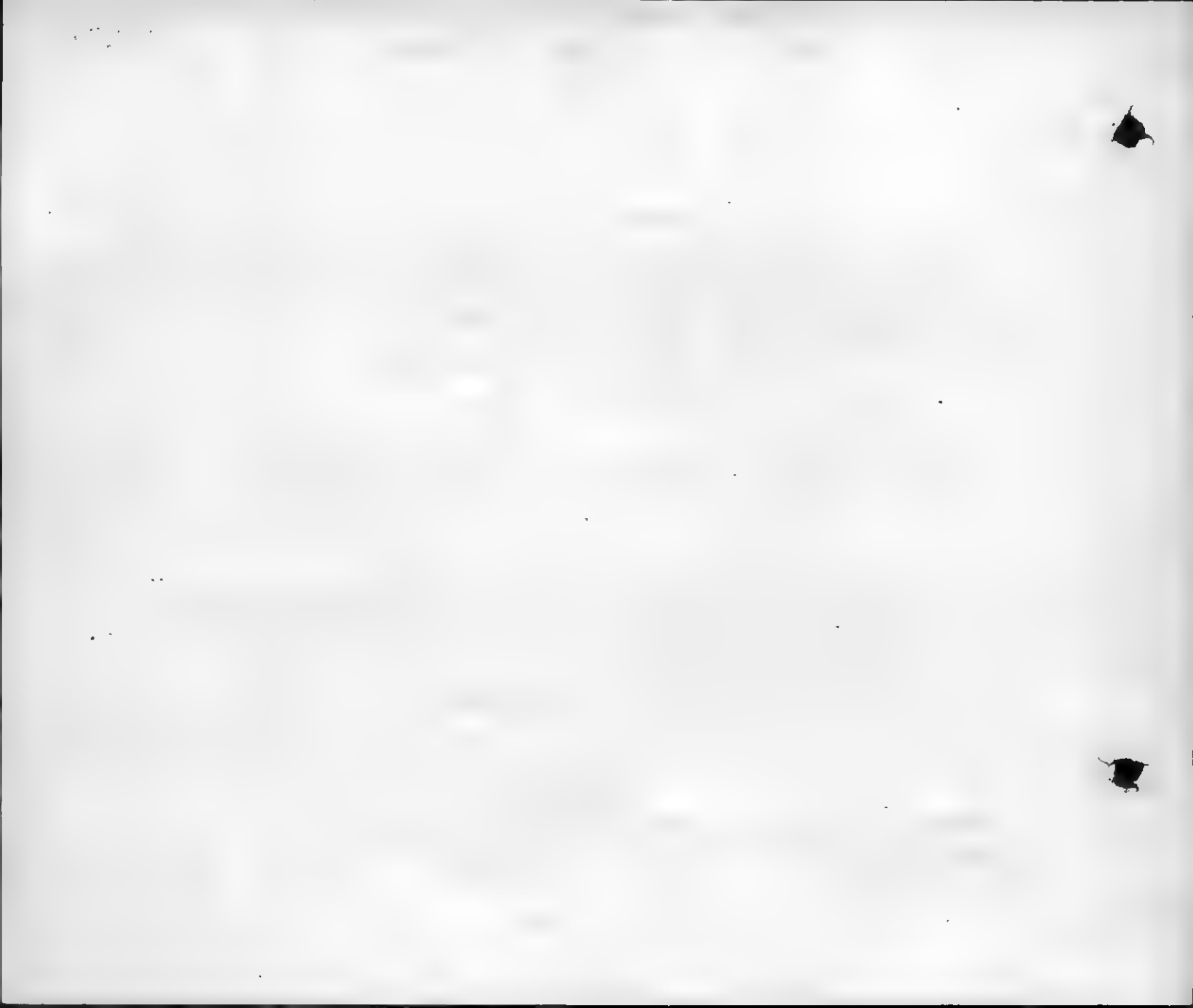
13073

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>SALISBURY</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c LENGTH OF STAY IN 1b <u>12</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Salisbury General Hospital</u>		d STREET ADDRESS <u>Salisbury 2-4-1</u>	
3 NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>F</u> Last <u>DUNN</u>		4 DATE OF DEATH Month <u>NOVEMBER</u> Day <u>26</u> Year <u>1958</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>NOV 25 1925</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) <u>33</u>
		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12 CITIZEN OF WHAT COUNTRY <u>USA</u>
13. FATHER'S NAME <u>Richard F. Fletcher</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. J. Dunn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16 SOCIAL SECURITY NO	17 INFORMANT <u>Mary A. J. Dunn</u> Address <u>1111 1/2 St. Salisbury Md.</u>
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Partial fetal atelectasis</u> DUE TO (b) <u>Cerebral edema and congestion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Fetal anoxia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 1/2 hrs</u> <u>15 1/2 hrs</u> <u>16 hrs</u>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour o. m. <u>11</u> p. m. <u>25</u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>
20f (City or town) <u>Salisbury</u>		(County) (State)	
21. I certify that I attended the deceased from <u>11/25/58</u> to <u>11/26/58</u> , that I last saw the deceased alive on <u>11/25/58</u> , 19 <u>58</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE <u>R. L. Henderson</u> M.D.		ADDRESS (Street, city or town, state) <u>702 Landan Ave Salisbury Md</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury Md</u>		DATE SIGNED <u>11/26/58</u>	
22a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/28/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Calvary</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>William F. Stewart</u>		24a. REC'D BY REGISTRAR <u>DEC 2 '58</u>	24b. REGISTRAR'S SIGNATURE <u>C. L. &amp; H. H. H.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13072

## CERTIFICATE OF DEATH

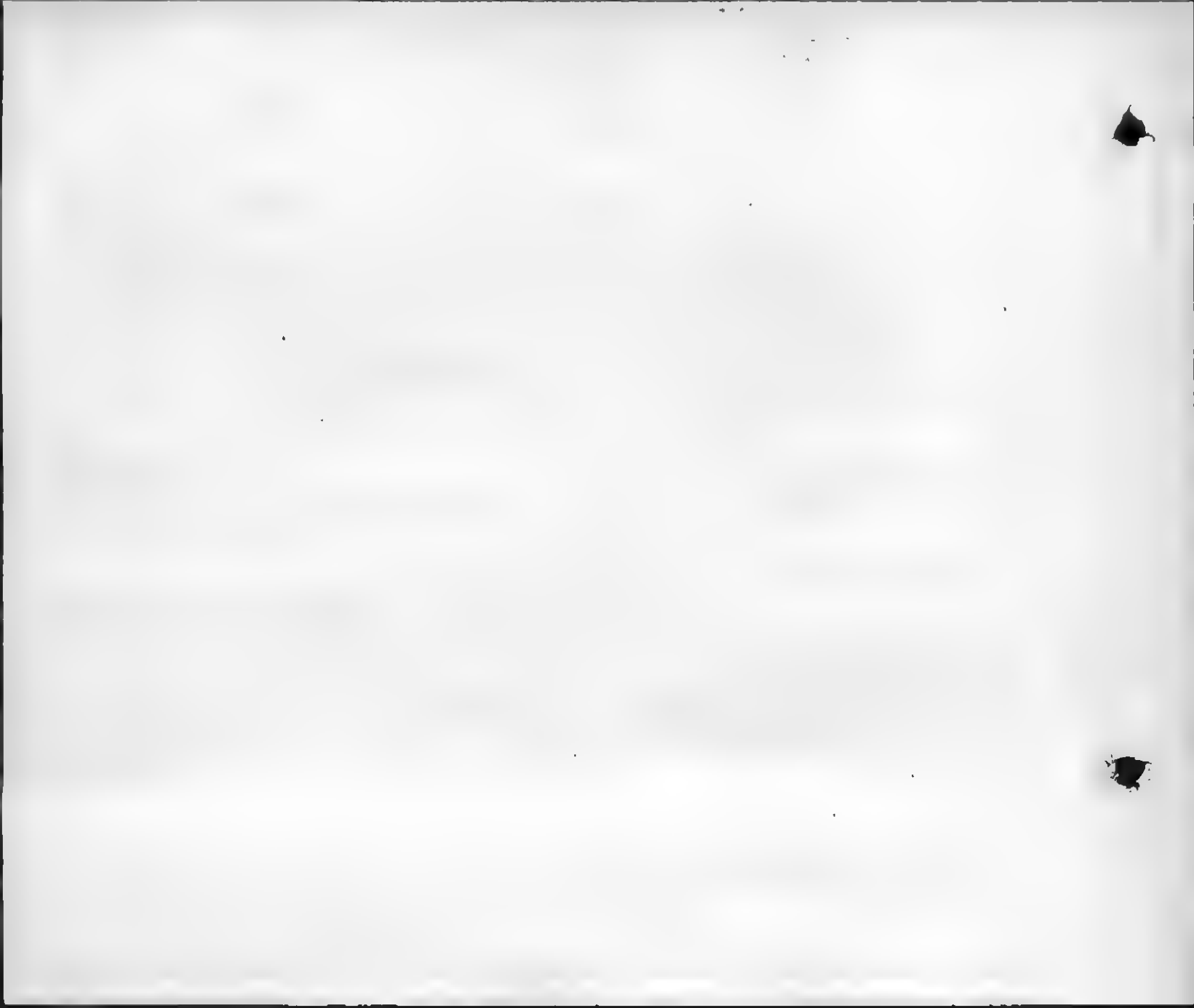
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial General Hospital</u>				d. STREET ADDRESS <u>710 Rose Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Infant</u> First Middle Last				4. DATE OF DEATH <u>November 20</u> 19 <u>58</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-18-58</u>	
9. AGE (In years last birthday) <u>2</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury Md</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>John Felton</u>		14. MOTHER'S MAIDEN NAME <u>Helena Ellis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>John Ellis</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (Birth Defect)</u> 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 18</u> , 19 <u>58</u> , to <u>Nov 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 20</u> , 19 <u>58</u> , and that death occurred at <u>3:20</u> A.M., from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>11/21/58</u>							
ACTUAL SIGNATURE <u>Richard C. Kline</u> M.D. <u>Medical Center</u>				PHYSICIAN'S NAME (Type) <u>Salisbury Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>11-21-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard M. West</u> ADDRESS				24a. REC'D BY REGISTRAR <u>REC 10 58</u>		24b. REGISTRAR'S SIGNATURE <u>Richard M. West</u>	

2082212XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13073

## CERTIFICATE OF DEATH

13074

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chincoteague, VA.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Tennant General Hospital</u>		d. STREET ADDRESS <u>512 Willow St.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>George</u> Middle <u>Ewell</u> Last <u>Ewell</u>		<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>10</u> Year <u>1958</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>MARCH 25, 1880</u>
<b>9. AGE</b> (In years last birthday) <u>78</u> yrs		<b>IF UNDER 1 YEAR</b> <input type="checkbox"/> <b>IF UNDER 24 HRS</b> <input type="checkbox"/> Months Days Hours Min	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>YARDMAN</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>VIRGINIA</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Alfred Ewell</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Eliza Ann Taylor</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>227057847</u>	
<b>17. INFORMANT</b> <u>Alice Ewell - Chincoteague, VA.</u>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Erythema Multiforme, Bullousum</u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. 19 <u>58</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>9-30</u> , 19 <u>58</u> , to <u>11-10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-10</u> , 19 <u>58</u> , and that death occurred at <u>6:40 P.M.</u> from the causes and on the date stated above			
<b>ACTUAL SIGNATURE</b> <u>William R. Ellis</u> M.D.		<b>ADDRESS</b> (Street, city or town, state) <u>Salisbury, Md</u>	
<b>PHYSICIAN'S NAME</b> (Type)		<b>DATE SIGNED</b> <u>11-10-58</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>11-13-58</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Stockton</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Stockton Md</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edgar Stanton - New Church, VA.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>NOV 14 1958</u>	
<b>ADDRESS</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Wm. R. Ellis</u>	



1  
FOR STATE  
HEALTH DEPT.

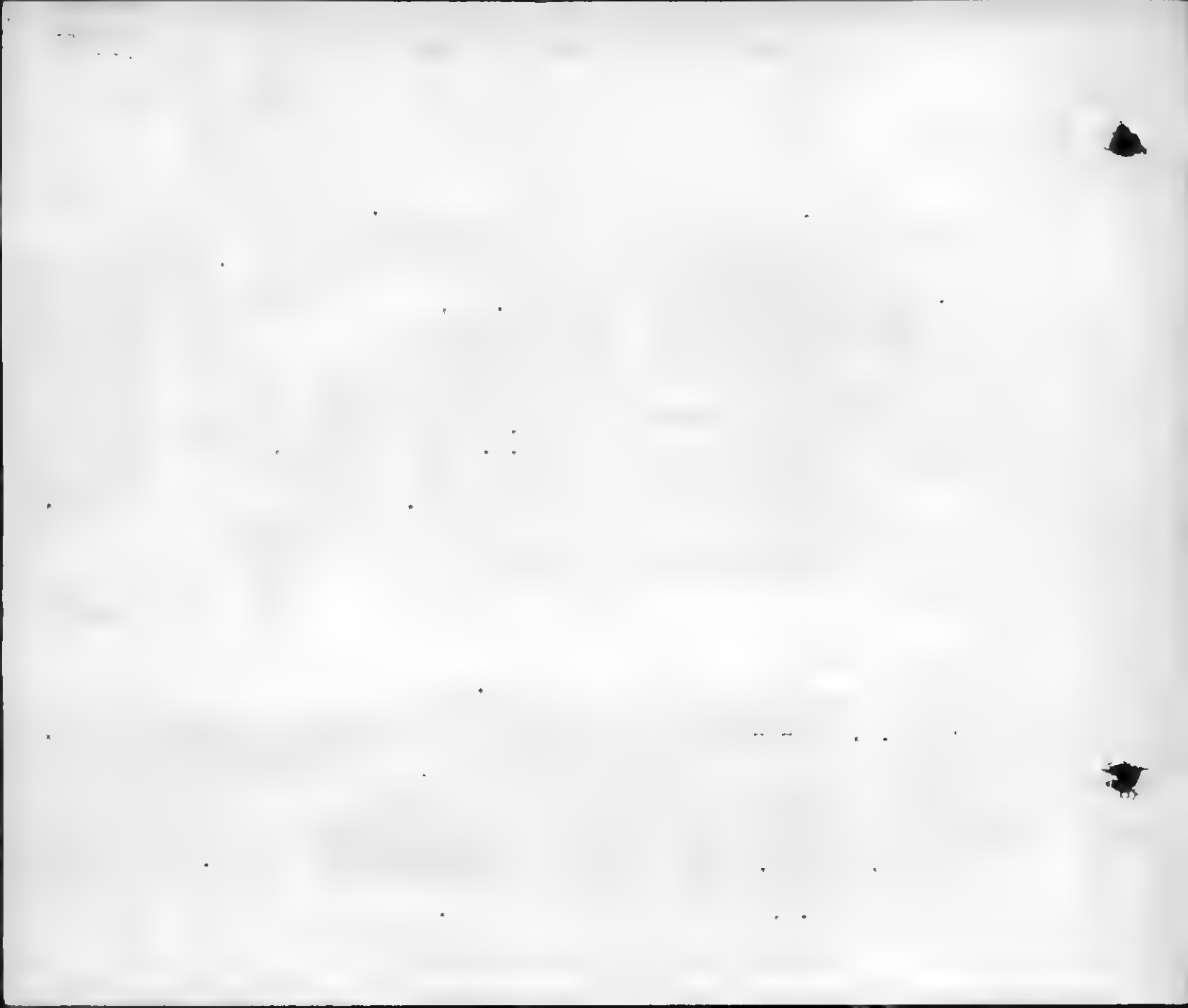
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13074 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13075

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>502 S. Division St</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b> First Middle Last		4. DATE OF DEATH <b>Nov. 6th 1958</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 26, 1896</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR <b>0</b> Months <b>10</b> Days	11. IF UNDER 24 HRS. <b>0</b> Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Night Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Kemp Fleenor</b>		14. MOTHER'S MAIDEN NAME <b>Belle Franklin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b> (If yes, give no. or dates of service)		16. SOCIAL SECURITY NO. <b>Informant</b>	
17. NAME OF INFORMANT <b>Mrs. Martha Ennis Adkins (Daughter)</b>		18. ADDRESS OF INFORMANT <b>R.D. # 2 Snow Hill, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gunshot wound of chest.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sudden.</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Shot self in chest.</b>			
19a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20a. TIME OF INJURY Month, Day, Year <b>2:25 P.M. 11-6-58</b>		20b. INJURY OCCURRED <b>Home</b> While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Salisbury</b>		20d. (City or town) (County) (State) <b>Wicomico Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		DATE SIGNED <b>Nov. 7 /1958</b>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 9, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Mem Park.</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		24. REGISTAR'S SIGNATURE <b>Arthur L. Evans</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>NOV 10 '58</b>	

THIS MEDICAL EXAMINER'S CERTIFICATE OF DEATH should be completed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

13075 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

13076

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kenosha General Hospital</u>		d. STREET ADDRESS <u>1404 East Church</u>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Fletcher</u> Last <u>Fletcher</u>		4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>May 22, 1924</u>
9. AGE (In years last birthday) <u>34</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Accomack County, Va</u>	
11. BIRTHPLACE (State or foreign country) <u>Accomack County, Va</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Ed. Fletcher</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Stevens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>218-22-862</u>	
17. INFORMANT <u>Bettie Stevens</u>		Address <u>Onancock, Va</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular renal disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>  </u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I attended the deceased from <u>10-18</u> , 19 <u>58</u> , to <u>11-5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-5</u> , 19 <u>58</u> , and that death occurred at <u>4:15</u> p. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip A. Insley</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Md</u>	
PHYSICIAN'S NAME (Type) <u>Philip A. Insley</u>		DATE SIGNED <u>11-7-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 10, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Joynes Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Onancock, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jedgar Thomas</u>		ADDRESS <u>Accomack, Va</u>	
24a. REC'D BY REGISTRAR <u>NOV 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Walter L. Thomas</u>	



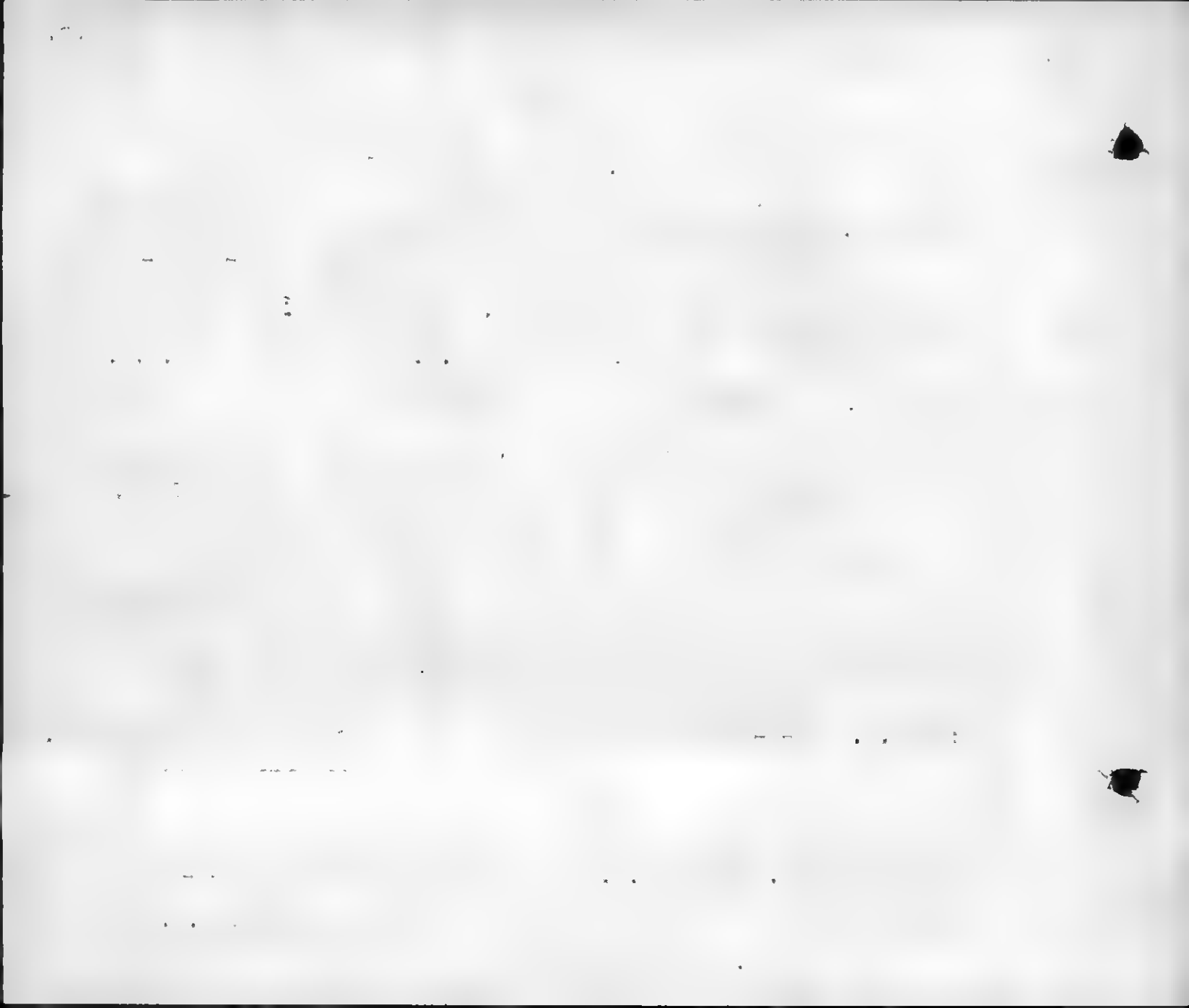
1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13076 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13077

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) b. STATE <u>North Carolina</u> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shallottle</u>	
c. LENGTH OF STAY IN 1b <u>1 Hr. 35 Mi</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>			
3. NAME OF DECEASED (Type or print) <u>First Alton</u> <u>Henry</u> <u>Henry</u> <u>Gales</u>		4. DATE OF DEATH Month <u>11-</u> Day <u>2-</u> Year <u>19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 15, 1936</u>	9. AGE (In years last b'day) <u>22</u> yes
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	11. BIRTHPLACE (State or foreign country) <u>N.C.</u>
13. FATHER'S NAME <u>Dannie W. Gales</u>		14. MOTHER'S MAIDEN NAME <u>Elvie Blanton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>237-54-0831</u>	
17. INFORMANT <u>Mr. Dannie Gales, Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest</u>			
825x DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Driver of car in accident on R F D # 13 near Pocomoke</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-7-58</u> Hour <u>11:25 P.M.</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>R F D # 13</u>	20f. (City or town) (County) (State) <u>Pocomoke Worcester Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/5/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chapel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Shallottle, N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co. Salisbury, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE NOV 5 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Norman D. Baker</u>		DATE SIGNED <u>11-2-58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



13077

## CERTIFICATE OF DEATH

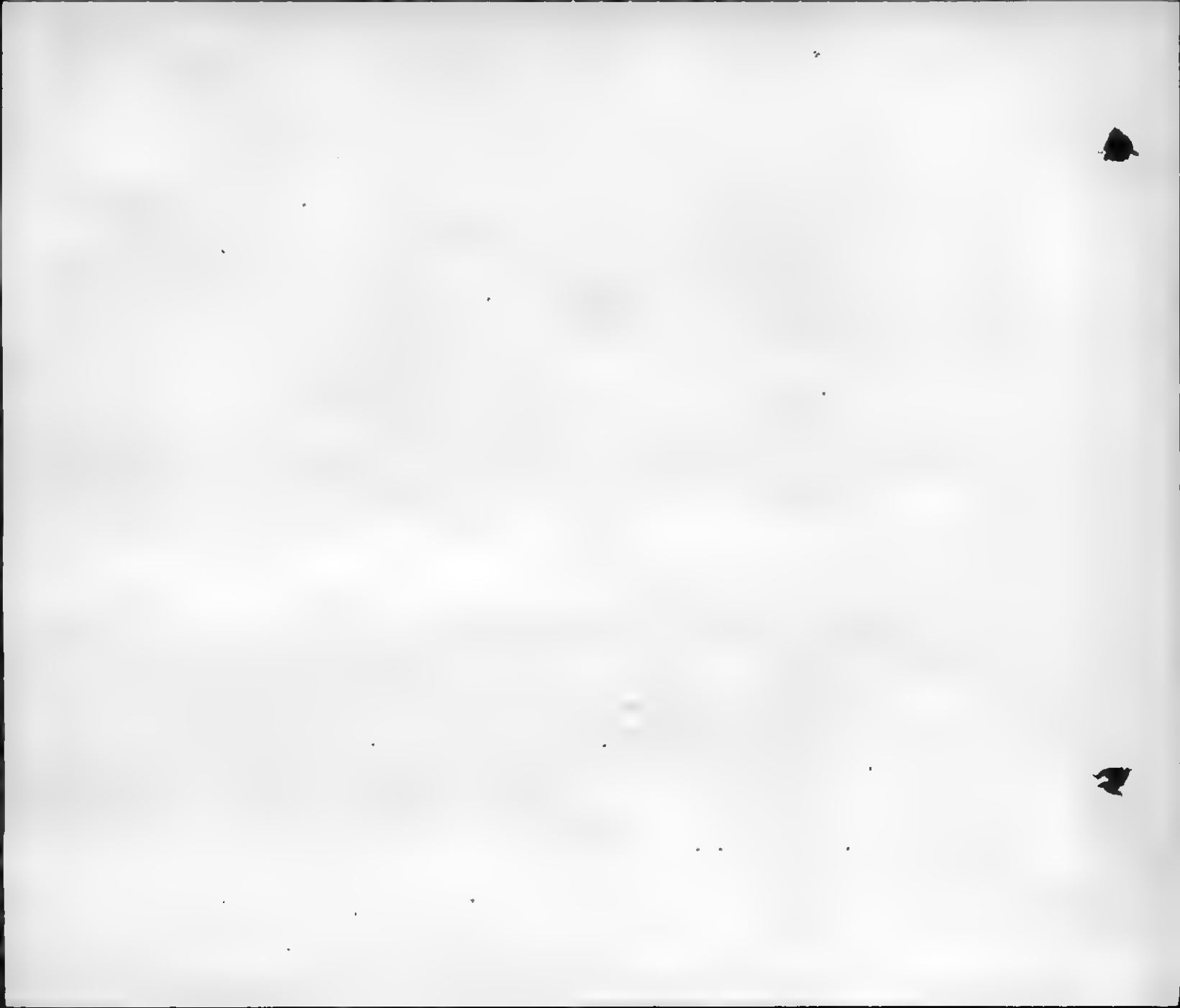
13078

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		c. LENGTH OF STAY IN lb <b>6 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Gracie</b> <b>A</b> <b>Graves</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>27</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1889</b>
9. AGE (In years last birthday) yrs. <b>69</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>19</b> Hours <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ed. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Octavia Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk</b>		16. SOCIAL SECURITY NO <b>unk</b>	
17. INFORMANT <b>Hospital Records</b>		Address <b>Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old Cerebral Hemorrhage</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 20, 1958</b> to <b>Nov. 27, 1958</b> , that I last saw the deceased alive on <b>Nov. 27, 1958</b> , and that death occurred at <b>4:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>11/27/58</b> ACTUAL SIGNATURE <b>L. Maldve</b> M.D. PHYSICIAN'S NAME (Type) <b>L. Maldve, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 30, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bigwoods Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>near Worton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth Walby</b>		24a. REC'D BY REGISTRAR DATE <b>Dec 1 '58</b>	
ADDRESS <b>Chestertown Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be registered with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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HEALTH DEPT.

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VS A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13078

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13079

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission, a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside of corporate limits, write R.U.R.A. and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Princess Anne</u> <u>19x</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. STREET ADDRESS <u>88 Hampton Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Hector</u> Middle <u>Hayward</u> Last <u></u>		4. DATE OF DEATH Month <u>11-</u> Day <u>22-</u> Year <u>19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1957</u>
9. AGE (In years last birthday) <u>1</u> yrs		10. IF UNDER 1 YEAR <u>5</u> Months <u></u> Days <u></u> Hours <u></u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Md. U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Thomas Hayward</u>		14. MOTHER'S MAIDEN NAME <u>Caroline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mother: Caroline Hayward, P.A. Md.</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO <u>12.6</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Acute congestive heart failure</u> DUE TO (c) <u>Sickle cell anemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>3 hours.</u> <u>Months.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , <u>Inquiry</u> <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11-27-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/25/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Mark</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Jones Jr. Princess Anne Md</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR <u>DEC 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

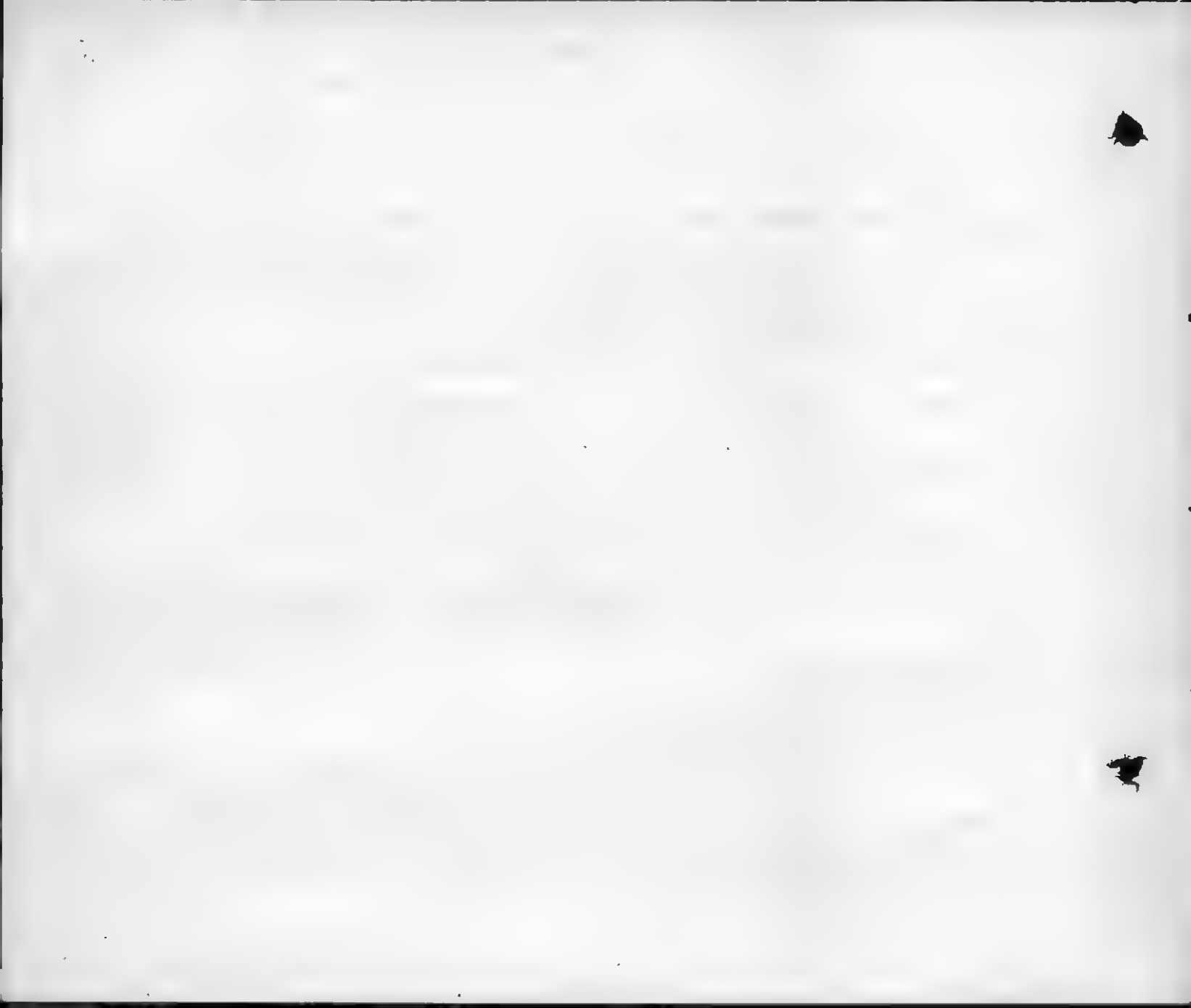
13079

## CERTIFICATE OF DEATH

Reg. Dist. No. 13080

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) d. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLSBORO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>400</u>	
3. NAME OF DECEASED (Type or print) First <u>Jerome</u> Middle <u>Henry</u> Last <u>Henry</u>		4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 27, 1904</u>
9. AGE (In years last birthday) <u>54</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poultry Plant</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Jerome Henry</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Alexandra</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>174-01-0421-1552</u>	
17. INFORMANT <u>Henry Millsboro Del.</u>		Address <u>Millsboro Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>WIDESPREAD METASTATIC CARCINOMA</u> DUE TO <u>CARCINOMA - LUNG - RT.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA - LUNG - RT.</u> (c) <u></u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8:25</u> 19 <u>Nov</u> , to <u>19</u> , that I last saw the deceased alive on <u>19</u> and that death occurred at <u>8:25</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>To: Gray, Rues and Medical Center Bldg - 19 Nov 1958</u>		DATE SIGNED <u>19 Nov 1958</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11/23/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARMONY CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MILLSBORO - DEL.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Millsboro, Del.</u>		24a. REC'D BY REGISTRAR <u>NOV 28 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>James Millsboro, Del.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>	
c. LENGTH OF STAY IN 1b <b>Two Days</b>		d. STREET ADDRESS <b>419 Calvert Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Morris</b> Middle <b>---</b> Last <b>Hollins</b>		4. DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 5, 1890</b>
9. AGE (In years last birthday) <b>68 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unk.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Hollins</b>		14. MOTHER'S MAIDEN NAME <b>Unk.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO <b>YES Unk.</b>	
17. INFORMANT <b>Hospital Records - Salisbury, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b>			
42.2.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11/20</b> , 19 <b>58</b> , to <b>11/22</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/22</b> , 19 <b>58</b> , and that death occurred at <b>7:10 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. V. Maldve</b>		DATE SIGNED <b>Salisbury, Maryland 11/22/58</b>	
PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M.D.</b>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>11/26/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Janes Cemetery</b>	22d. LOCATION (City, town or county) (State) <b>Chestertown, C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth Walling</b>		24a. REC'D BY REGISTRAR <b>Chertown</b>	
ADDRESS <b>Chestertown</b>		24b. REGISTRAR'S SIGNATURE <b>Chertown</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13122

CERTIFICATE OF DEATH

Reg. Dist. No.

13082

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>				c. LENGTH OF STAY IN IB <b>35 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>906 State Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Amy</b> Middle <b>Wilson</b> Last <b>Horsey</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>5</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 20, 1894</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR: Months <b>6</b> Days <b>10</b> Hours <b>15</b> Min <b>00</b>		IF UNDER 24 HRS: Hours <b>15</b> Min <b>00</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Frank Wheatley</b>				14. MOTHER'S MAIDEN NAME <b>Tamsey Williams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-----</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Andrew N. Horsey, Delmar, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral failure</b> DUE TO <b>430.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO <b>410.0</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour <b>19</b> Month <b>11</b> Day <b>5</b> Year <b>19 58</b> a. m. <b>00</b> p. m. <b>00</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Delmar</b>				20g. (County) <b>Wicomico</b>		20h. (State) <b>MD</b>	
21. I certify that I attended the deceased from <b>8/2</b> , 19 <b>58</b> , to <b>death</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/5</b> , 19 <b>58</b> , and that death occurred at <b>2 P.</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. M. Larmore</b> M.D.				ADDRESS (Street, city or town, state) <b>100 Coast Delmar, Del.</b>			
DATE SIGNED <b>11/6/58</b>				DATE SIGNED <b>11/6/58</b>			
PHYSICIAN'S NAME (Type) <b>E. M. LARMORE</b>				DELMAR, DEL.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-8-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>		22d. LOCATION (City, town, or county) (State) <b>Delmar, Del.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. S. Marvel Co - Delmar, Del.</b>				24a. REC'D BY REGISTRAR <b>NOV 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hand</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



FOR STATE  
HEALTH DEPT.

13123

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

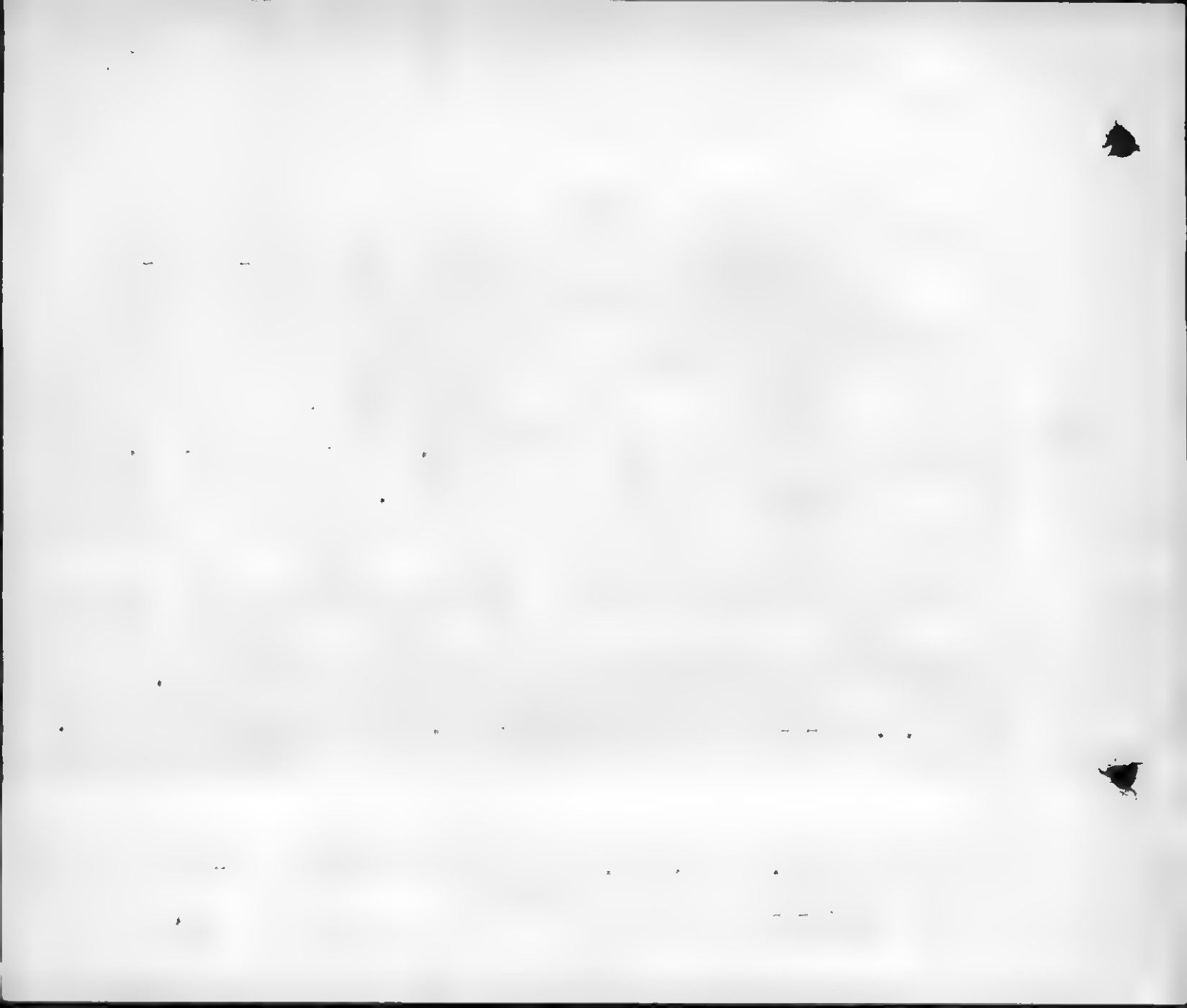
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13083

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bivalve</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bivalve</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jesse B Insley</u>		4. DATE OF DEATH Month Day Year <u>11-6-1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-1901</u>
9. AGE (in years last birthday) <u>57</u> yrs		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>28</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Robert L. Insley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Louisa ?</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>-----</u>	
17. INFORMANT <u>William R. Insley</u>		Address <u>Bivalve, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of chest.</u> DUE TO (b) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Shot self in chest with sawed off shot gun.</u>	
20c. TIME OF INJURY Month, Day, Year <u>4 P.M. 11-6-58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home-yard.</u>	20f. (City or town) (County) (State) <u>Bivalve</u> <u>Wicomico</u> <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
27a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		27b. DATE THEREOF <u>11-9-58</u>	
27c. NAME OF CEMETERY OR CREMATORY <u>Bivalve Cemetery</u>		27d. LOCATION (City, town, or county) (State) <u>Bivalve</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Messitt</u>		ADDRESS <u>Bivalve, Maryland</u>	
24a. REC'D BY REGISTRAR <u>NOV 14 '58</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the ward "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13081

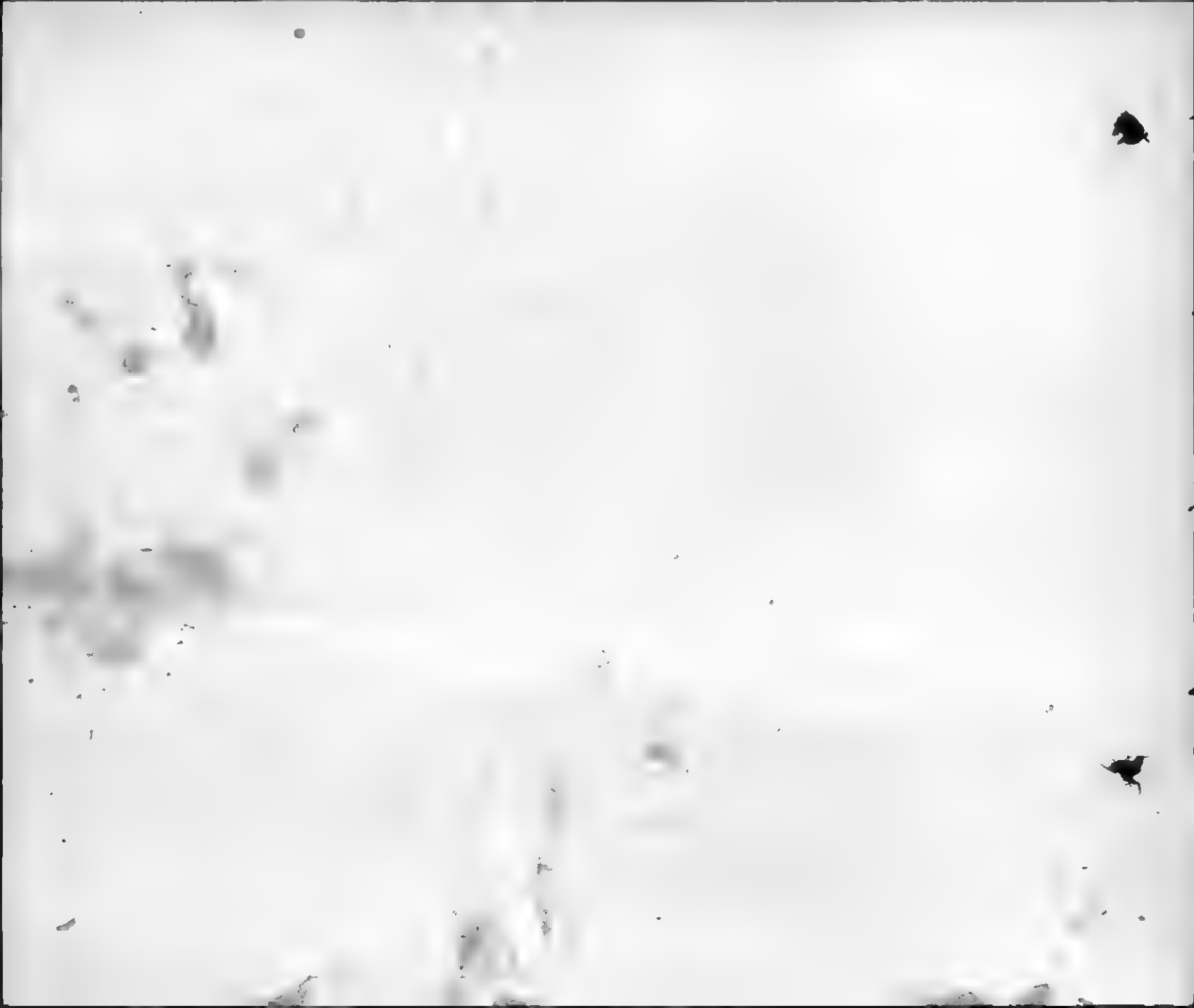
## CERTIFICATE OF DEATH

13084

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>OSCAR C JAMES</u>				4. DATE OF DEATH Month Day Year <u>NOVEMBER 2 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Feb 17, 1889</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>+</u> Days <u>+</u> Hours <u>+</u> Mins <u>+</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSERY OWNER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Plants</u>			
13. FATHER'S NAME <u>BRANSTON JAMES</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE ROGERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>821-26-1505</u>			
17. INFORMANT <u>MARION DeHAINNOUT</u> Address <u>SEAFORD RD Dd.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> 4-0-0-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 days</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>October 31, 1958</u> to <u>Nov. 2, 1958</u> , that I last saw the deceased alive on <u>November 3, 1958</u> , and that death occurred at <u>11:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. G. G. G.</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>			
DATE SIGNED <u>11-2-58</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE/TIME OF <u>11/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ODD Fellows Cem</u>		22d. LOCATION (City, town, or county) (State) <u>LAUREL Del</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. DeHainnout</u> ADDRESS <u>Seaford Dd.</u>				24a. REC'D BY REGISTRAR <u>NOV 5 58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>William R. G. G.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13082**  
**CERTIFICATE OF DEATH**

13085

Reg. Dist. No.

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>				<b>2 USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>18 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Faulkner</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>--</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3 NAME OF DECEASED</b> (Type or print) First <u>Laura</u> Middle <u>--</u> Last <u>Jordan</u>				<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 12, 1886</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>12</u> Days <u>14</u> Hours <u>14</u> Min. <u>58</u>		IF UNDER 24 HRS Months <u>12</u> Days <u>14</u> Hours <u>14</u> Min. <u>58</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>--</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Jackson</u>			
14. MOTHER'S MAIDEN NAME <u>Anna Jackson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>--</u>				17. INFORMANT <u>Hospital Records, Salisbury, Maryland</u>			
<b>18 CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: <u>715X</u> IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> DUE TO <u>Septicemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>Multiple decubiti</u> (b) <u>Septicemia</u> DUE TO <u>Multiple decubiti</u> (c) <u>Multiple decubiti</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>4 days</u> <u>Weeks</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>General Arteriosclerosis, Left Hemiplegia, Diabetes Mellitus</u>						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Salisbury, Maryland</u>	
20f. (City or town) (County) (State) <u>Salisbury, Maryland</u>						21. I certify that I attended the deceased from <u>Oct. 27, 1958</u> to <u>Nov. 14, 1958</u> , that I last saw the deceased alive on <u>Nov. 14, 1958</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>						DATE SIGNED <u>11/14/58</u>	
ACTUAL SIGNATURE <u>G. Kosmahly</u> M.D. <u>Salisbury, Maryland</u>						PHYSICIAN'S NAME (Type) <u>G. Kosmahly, M.D.</u> <u>Deer's Head State Hospital</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shilo M.E.</u>			
22d. LOCATION (City, town, or county) (State) <u>Shilo M.E.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>		ADDRESS <u>Waldorf, Md.</u>			
24a. REC'D BY REGISTRAR <u>NOV 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. S. Hanna</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

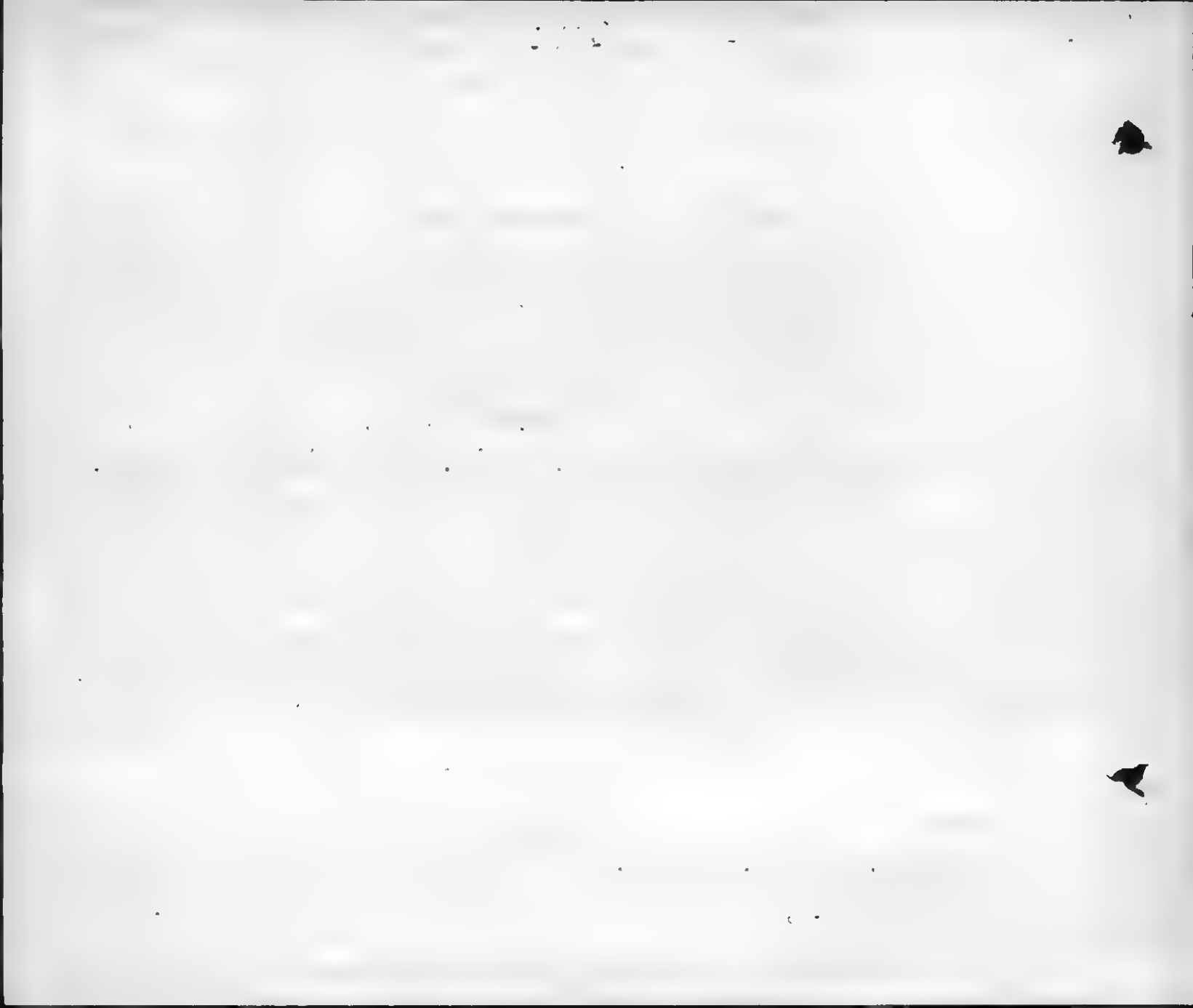
VS A15 (4)  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13083- CERTIFICATE OF DEATH

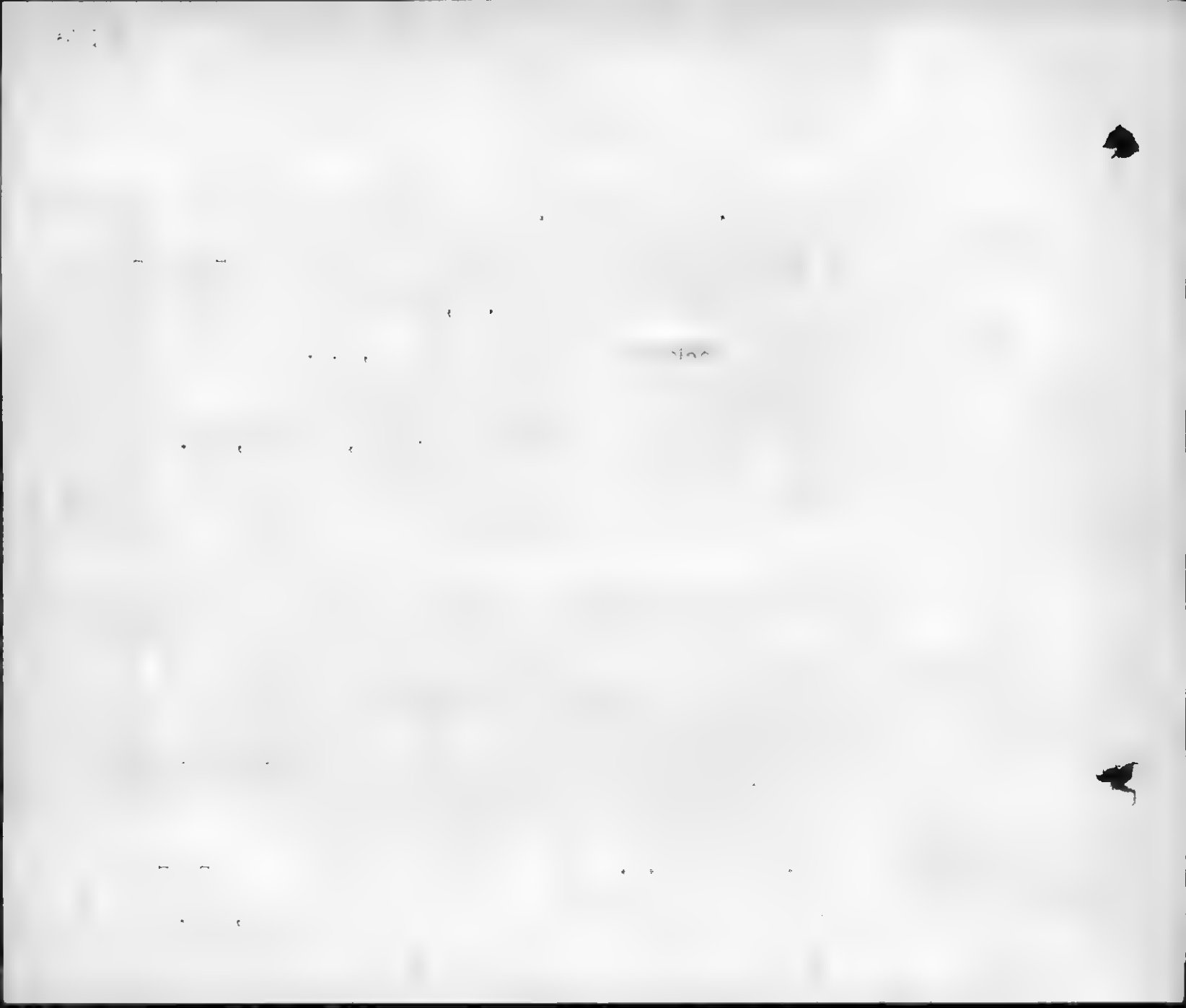
13086

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>William RUDOLPH Kelly</u>		4 DATE OF DEATH Month Day Year <u>November 30 1958</u>	
5. SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Erick Mason (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Annie Yow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unk</u>		16 SOCIAL SECURITY NO. <u>17. INFORMANT <u>Mrs. Beatrice M. Kelly (Wife) 302 E. Locust St. Salisbury, Maryland</u></u>	
18 CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>Myocardial Infarction</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial Infarction</u> INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>11/29 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/14</u> , 19 <u>58</u> , to <u>11/30</u> , 19 <u>58</u> , that I lost saw the deceased alive on <u>11/29</u> , 19 <u>58</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Thomas C. Hill Jr. M.D.</u>		DATE SIGNED <u>11/30/58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Thomas C. Hill Jr.</u>		DATE SIGNED <u>11/30/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 4, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Couldree Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Moore County-N. Carolina</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>		24a REC'D BY REGISTRAR <u>DEC 2 '58</u> DATE	
24b REGISTRAR'S SIGNATURE <u>2-11-58</u>			



1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hebron</u>		c. LENGTH OF STAY IN 1b <u>X</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hebron</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Marvil Packing Co. Hebron, Md.</u>			f. STREET ADDRESS <u>Church</u>		
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Lake</u> Last <u>Kimney</u>			4. DATE OF DEATH Month <u>11</u> Day <u>26</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 18, 1906</u>		9. AGE (In years last birthday) <u>52</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Package making</u>		11. BIRTHPLACE (State or foreign country) <u>Secretary, Md.</u>	
13. FATHER'S NAME <u>Benjamin Kimney</u>			14. MOTHER'S MAIDEN NAME <u>Emma Short</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>***** 213-03-4697</u>		17. INFORMANT <u>Minnie Kimney, Hebron, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>11-27-58</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-29-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Firemans</u>	22d. LOCATION (City, town, or county) <u>Sharptown, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Sharptown, Md.</u>		ADDRESS <u>1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles W. Sharptown</u>	



# BALTIMORE, 18

## 13125

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 13089

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="margin-left: 100px;">Wicomico</span> <span style="margin-left: 100px;">MARYLAND</span>				<b>2 USUAL RESIDENCE</b> (Where deceased lived If institution; Residence before admission) a. STATE <span style="margin-left: 100px;">Maryland</span> <span style="margin-left: 100px;">b. COUNTY Wicomico</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="margin-left: 100px;">Mardela</span>			c. LENGTH OF STAY IN 1b <span style="margin-left: 100px;">Mardela (Rural)</span>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <span style="margin-left: 100px;">R.D.# 1</span>				d. STREET ADDRESS <span style="margin-left: 100px;">R.D.# 1</span>			
<b>3. NAME OF DECEASED</b> (Type or print) <span style="margin-left: 100px;">First WILLIAM Middle McKINIEY Last KNOWLES</span>				<b>4. DATE OF DEATH</b> <span style="margin-left: 100px;">Month NOV. Day 28th Year 19 58</span>			
<b>5. SEX</b> <span style="margin-left: 100px;">Male</span>		<b>6. COLOR OR RACE</b> <span style="margin-left: 100px;">White</span>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <span style="margin-left: 100px;">July 3, 1904</span>		<b>9. AGE</b> (In years last birthday) yrs. <span style="margin-left: 100px;">54</span>		<b>10. IF UNDER 1 YEAR</b> Months <span style="margin-left: 10px;">4</span> Days <span style="margin-left: 10px;">23</span> Hours <span style="margin-left: 10px;"></span> Min <span style="margin-left: 10px;"></span>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="margin-left: 100px;">School Bus Operator</span>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="margin-left: 100px;">Riverton, Maryland</span>				
<b>11. BIRTHPLACE</b> (State or foreign country) <span style="margin-left: 100px;">U S A</span>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="margin-left: 100px;">U S A</span>				
<b>13. FATHER'S NAME</b> <span style="margin-left: 100px;">Rufus D. Knowles</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="margin-left: 100px;">Melissa Hearn</span>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes no or unknown) <span style="margin-left: 100px;">No</span> <span style="margin-left: 100px;">(If yes, give war or dates of service)</span>			<b>16. SOCIAL SECURITY NO.</b> <span style="margin-left: 100px;"></span>				
<b>17. INFORMANT</b> Address <span style="margin-left: 100px;">Mrs. Eleanor C. Knowles (Wife) R.D.# 1 Mardela, Maryland</span>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="margin-left: 100px;">Cerebral Hemorrhage</span> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <span style="margin-left: 100px;">Vagotomized cerebral arteriosclerosis</span> DUE TO (c) <span style="margin-left: 100px;"></span>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <span style="margin-left: 100px;">1 day</span>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <span style="margin-left: 100px;">Renal ischemia and pulmonary arteriosclerosis</span>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <span style="margin-left: 100px;">19</span> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I attended the deceased from</b> <span style="margin-left: 100px;">11/20, 1958</span> <b>to</b> <span style="margin-left: 100px;">death</span> <b>19</b> <span style="margin-left: 100px;">1958</span> <b>that I last saw the deceased alive on</b> <span style="margin-left: 100px;">11/28, 1958</span> <b>and that death occurred at</b> <span style="margin-left: 100px;">9:25 P. M.</span> <b>from the causes and on the date stated above.</b>							
<b>ACTUAL SIGNATURE</b> <span style="margin-left: 100px;">Ernest M. Larmore</span>			<b>DATE SIGNED</b> <span style="margin-left: 100px;">Nov. 30, 1958</span>				
<b>PHYSICIAN'S NAME (Type)</b> <span style="margin-left: 100px;">Dr. Ernest M. Larmore</span>			<b>ADDRESS (Street, city or town, state)</b> <span style="margin-left: 100px;">Delmar, Delaware</span>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="margin-left: 100px;">Burial</span>		<b>22b. DATE THEREOF</b> <span style="margin-left: 100px;">Dec. 1, 1958</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="margin-left: 100px;">Riverton Church Cemetery</span>			
<b>22d. LOCATION (City, town, or county)</b> <span style="margin-left: 100px;">Riverton, Maryland</span>		<b>22e. (State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="margin-left: 100px;">HOLLOWAY &amp; COMPANY</span>			<b>ADDRESS</b> <span style="margin-left: 100px;">SALISBURY MARYLAND</span>				
<b>24a. REC'D BY REGISTRAR</b> <span style="margin-left: 100px;">DEC 3 '58</span>		<b>24b. REGISTRAR'S SIGNATURE</b> <span style="margin-left: 100px;">Arthur S. Kraw</span>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

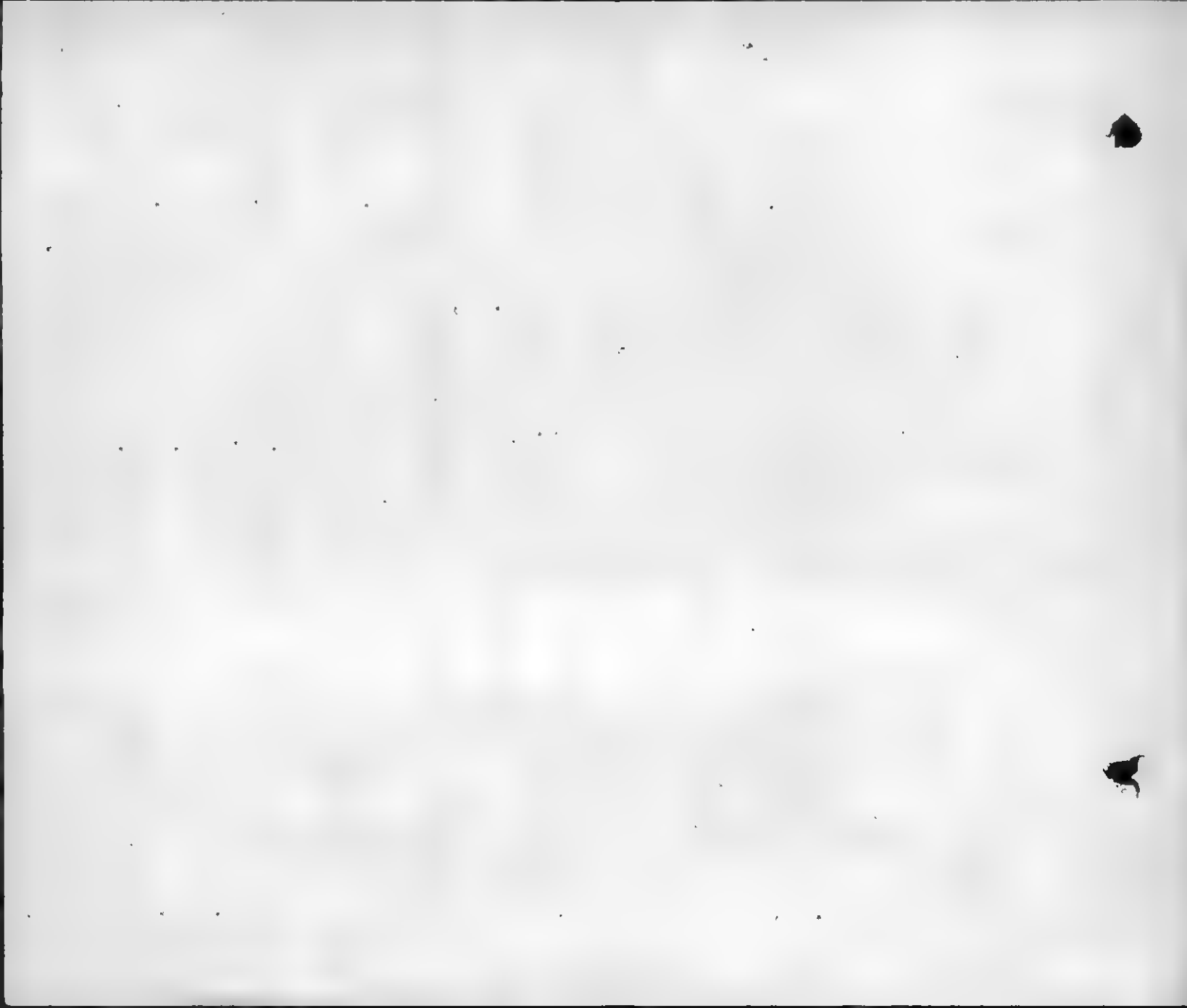
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13084 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13090

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pen Gen. Hospital</b>		e. STREET ADDRESS <b>515 S. Pinehurst Ave.</b>	
f. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RUTH</b> Middle <b>LITOW</b> Last <b>LITOW</b>		4. DATE OF DEATH Month <b>11</b> Day <b>9</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 7, 1905</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>9</b>	IF UNDER 24 HRS. Hours <b>11</b> Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Philadelphia Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Morris - - - - -</b>		14. MOTHER'S MAIDEN NAME <b>No Record</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Leon Goldstein</b>		Address <b>5625 Woodcrest Ave. Phila. Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>3 min</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <b>Philip A. Insley</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Philip A. Insley</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 10, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Roosevelt Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Philadelphia, Pa. (Bucks Co.)</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>NOV 13 58</b>		24b. REGISTRAR'S SIGNATURE <b>Calvin S. Kraus</b>	



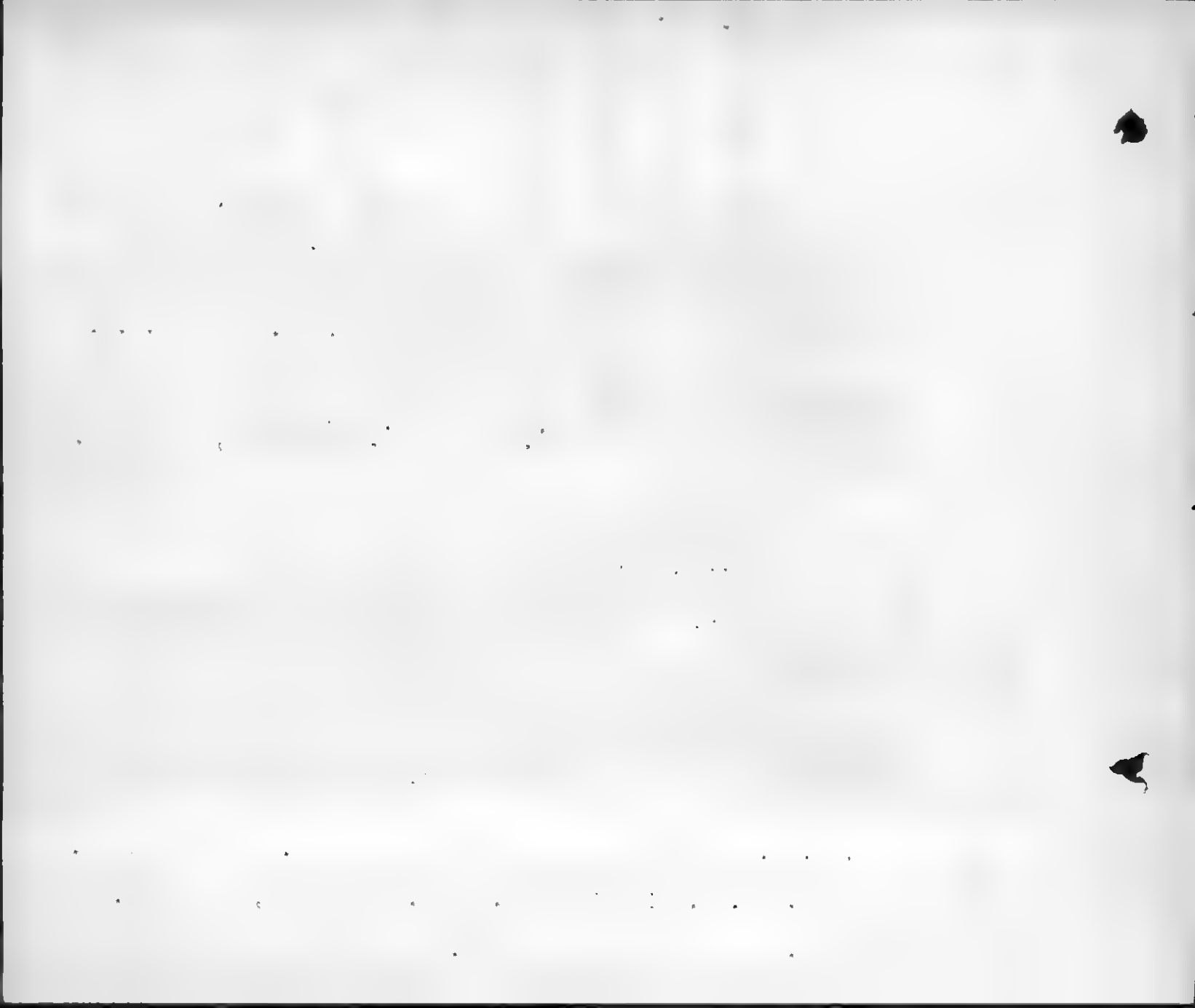
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13085 CERTIFICATE OF DEATH

13088

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <i>Maryland</i> c. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>RAMSDELL GENERAL HOSPITAL</i>		d. STREET ADDRESS <i>817 Cooper St.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>James Daniel Mac Knight Mac Knight</i>		4. DATE OF DEATH Month Day Year <i>November 19, 1958</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>November 19, 1958</i>
9. AGE (In years, last birthday) yrs. <i>5</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Salisbury, Md.</i>		12. CITIZENSHIP OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Raymond Louis Mac Knight</i>		14. MOTHER'S MAIDEN NAME <i>Cecilia Sharpe</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. Raymond L. Mac Knight (Father)</i> <i>817 Cooper St. Salisbury, Maryland.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>7:15 AM</i> DUE TO <i>Intrauterine hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Anoxia</i> DUE TO (c) <i>Excessive bleeding Placenta Previa</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>1 hour</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Prematurity (28 wks pregnancy)</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/19/1958</i> to <i>11/19/1958</i> that I last saw the deceased alive on <i>11/19/1958</i> and that death occurred at <i>9:45 AM</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <i>11-21-58</i>	
ACTUAL SIGNATURE <i>[Signature]</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>Dr. J. J. Burton</i>		<i>211 Maryland Ave. Salisbury, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		22b. DATE THEREOF <i>Nov. 20.58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Wicomico Mem. Park.</i>		22d. LOCATION (City, town, or nearest town) (State) <i>Salisbury, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Holloway &amp; Co.</i>		ADDRESS <i>Salisbury, Maryland</i>	
24a. REC'D BY REGISTRAR <i>NOV 24 '58</i>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13086 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13091

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN TB <u>2 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springhill Sanitarium</u>		d. STREET ADDRESS <u>Route 2 Berlin</u>	
3. NAME OF DECEASED (Type or print) <u>Algia</u> <u>Reginald</u> <u>Mariner</u>		4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-6-1883</u>
9. AGE (In years at birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u> Hours <u>58</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin A. Mariner</u>		14. MOTHER'S MAIDEN NAME <u>Suzan Holland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mr. Reginald Mariner, Berlin, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sub dural hematoma, left.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic cardio-vascular disease</u> DUE TO (c) <u>Acute myocardial infarction</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-sclerotic cardio-vascular disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DECEASED HAD INJURY OCCURRED PRIOR TO DEATH AND REQUIRED RESTRAINTS, yet on <u>11-18-58</u> got out of restraints and over side & fell on <u>head.</u>	
20c. TIME OF INJURY Month, Day, Year <u>2-4 P.M. 11-18-58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>		20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) <u>BERLIN</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna B. Berkey</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE	

Film G237 - 1/15/59 - Originally this death was filed on a regular death certificate form, but later found to be a medical examiner's, so this certificate was filed. mb

13087

## CERTIFICATE OF DEATH

13092

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>5 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Mathias</u> Middle <u>T</u> Last <u>Marshall</u>		4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>19 58</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/25/1867</u>
9. AGE (In years lost birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Mathias T. Marshall</u>	
14. MOTHER'S MAIDEN NAME <u>Esther Ann Hopkins</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>None.</u>	
16. SOCIAL SECURITY NO		17. INFORMANT <u>Mr. Wm E. Marshall (Brother) R.D.# Shad Point Salisbury, Maryland</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent CVA</u> <u>331X</u> DUE TO General arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous CVI with residual left hemiplegia; arteriosclerotic heart disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I attended the deceased from <u>June 4</u> , 19 <u>58</u> , to <u>Nov. 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 12</u> , 19 <u>58</u> , and that death occurred at <u>1:40 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>11/12/58</u>			
ACTUAL SIGNATURE <u>G. Kosmahly</u> M D		PHYSICIAN'S NAME (Type) <u>G. Kosmahly, M. D.</u> <u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 15, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Shad Point Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>R.D.# Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a REC'D BY REGISTRAR <u>NOV 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Colin S. Fenn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13088

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SELESDURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u>	
c. LENGTH OF STAY IN 1b <u>10 yrs</u>		d. STREET ADDRESS <u>7 JEWEL STREET</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LEWIS &amp; CLARK General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARENCE H. MATTHEWS</u>		4. DATE OF DEATH <u>November 7, 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-1879</u>
9. AGE (In years last birthday) <u>79</u> yes		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAR INSPECTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>	
11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry C Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>716-01-9440</u>	
17. INFORMANT <u>Agnes Matthews, Delmar Del</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis, acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Benign prostatic hypertrophy</u>		<u>6 hours</u> <u>10 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of stem 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 26</u> , 19 <u>55</u> , to <u>Nov 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 9</u> , 19 <u>58</u> , and that death occurred at <u>11 A.</u> M., from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Raymond M. Yaw</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Nov 11/58</u>	
PHYSICIAN'S NAME (Type) <u>Raymond M. Yaw, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-12-58</u>	
22c. NAME OF CEMETERY OR CREMATOR <u>St. John's</u>		22d. LOCATION (City, town, or county) (State) <u>Delmar Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Mamel Co. - Delmar Del.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>NOV 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

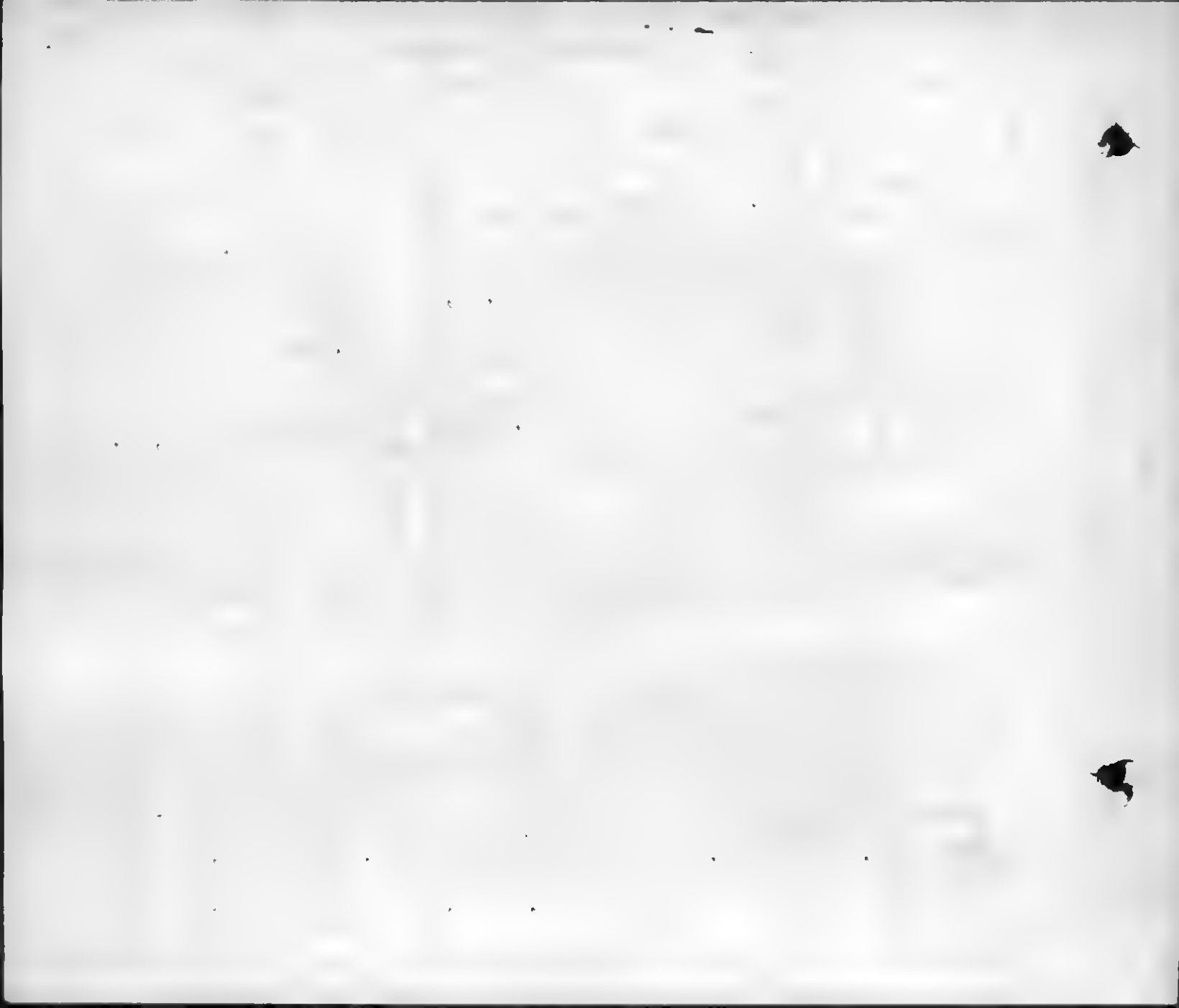
13094

13089

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen. Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
f. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen. Hospital</b>		g. STREET ADDRESS <b>315 Park Ave</b>	
h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>DELLA</b> Middle <b>FLORENCE</b> Last <b>McDANIEL</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>10th</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Aug. 31, 1876</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min <b>82</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11 BIRTHPLACE (State or foreign country) <b>Worcester Co. Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13 FATHER'S NAME <b>William Jones</b>		14 MOTHER'S MAIDEN NAME <b>Ada Fleming</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <b>403</b>	
17. INFORMANT <b>Mrs. Rebecca Wolfe (Grand-Daughter)</b>		18. ADDRESS <b>Venton Place Salisbury, Md.</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> INTERVAL BETWEEN ONSET AND DEATH <b>0.10 hrs</b>			
DUE TO <b>Acute Cardiac failure</b> ?			
DUE TO <b>Arteriosclerotic C-V Disease</b> ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/10, 1958</b> , to <b>10/10, 1958</b> , that I last saw the deceased alive on <b>10/10, 1958</b> , and that death occurred at <b>10:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William D. Gray</b>		M.D. <b>Nov. 12/1958</b>	
PHYSICIAN'S NAME (Type) <b>Dr. William D. Gray</b>		<b>334 Camden Ave. Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>Nov. 13th, 1958</b>	<b>Parsons Cemetery</b>	<b>Salisbury, Maryland</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a REC'D BY REGISTRAR <b>NOV 13 '58</b>		24b REGISTRAR'S SIGNATURE <b>William S. Huns</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

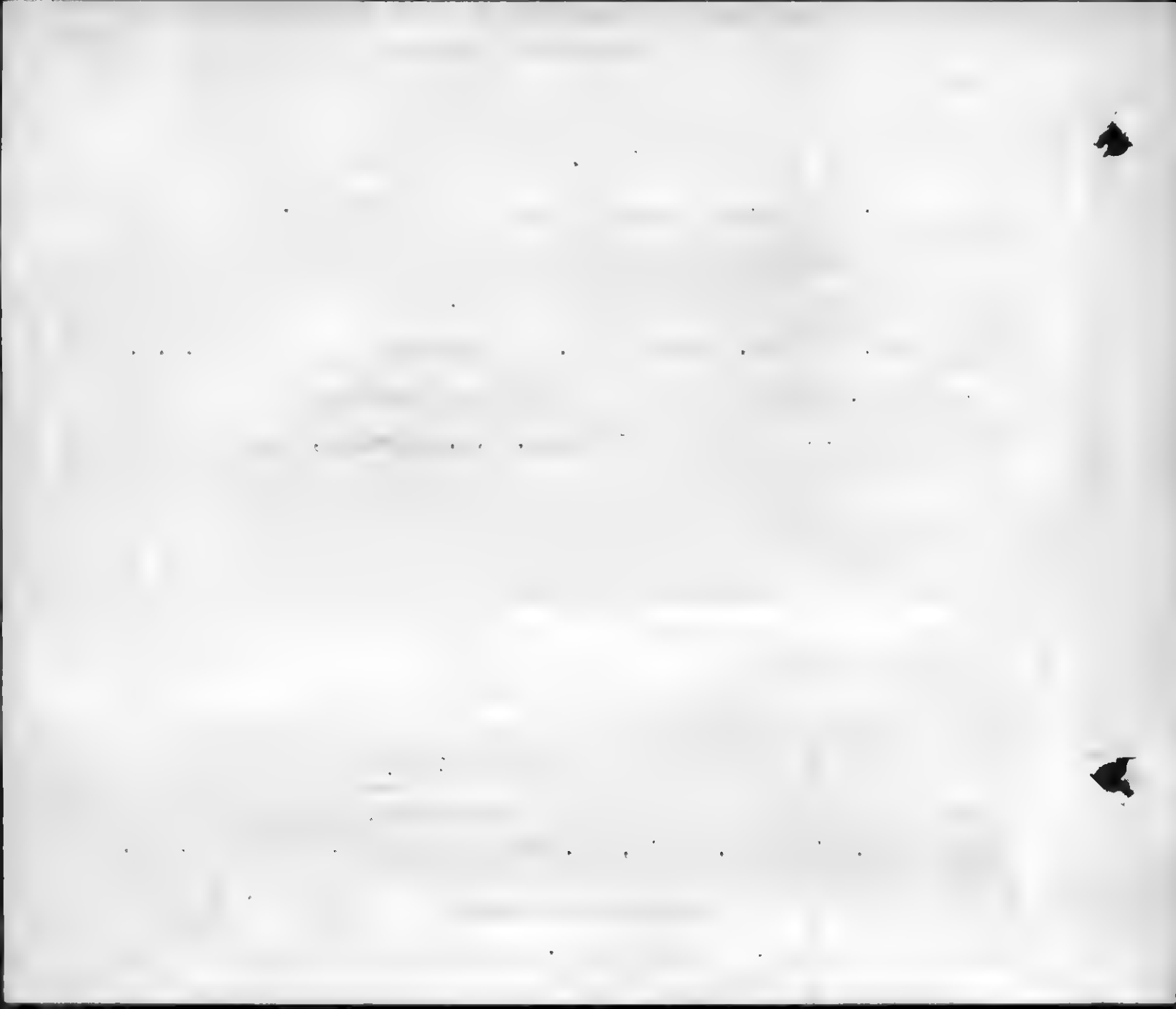
13126

## CERTIFICATE OF DEATH

Reg. Dist. No.

13095

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b>				c. LENGTH OF STAY IN TB <b>1 Hr.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>S. Division</b>				e. STREET ADDRESS <b>Pine Bluff Rd.,</b>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>James Morris McGrath</b>				4. DATE OF DEATH Month Day Year <b>11 3 1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan 29, 1903</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice Pres. &amp; Treas. Electric Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>			
11 BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13 FATHER'S NAME <b>Josiba V. McGrath</b>				14 MOTHER'S MAIDEN NAME <b>Mary Hastings</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-10-6478</b>			
17 INFORMANT <b>Mrs. J.M. McGrath, Same</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarct, acute</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>5 minutes</b> DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a m p. m. Month Day Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Salisbury</b>				20g. (County) <b>Maryland</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>11-3</b> , 19 <b>58</b> , to <b>11-3</b> , 19 <b>58</b> that I last saw the deceased alive on <b>11-3</b> , 19 <b>58</b> , and that death occurred at <b>5:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>11/4/58</b>							
ACTUAL SIGNATURE <b>Wilber R. Ellis, Jr.</b> M.D.				PHYSICIAN'S NAME (Type) <b>Dr. Wilber R. Ellis, Jr. Medical Center, Salisbury, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/6/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co, Salisbury, Md.</b>				24a. REC'D BY REGISTRAR <b>Nov 6 58</b>		24b. REGISTRAR'S SIGNATURE <b>Norman T. Baker</b>	



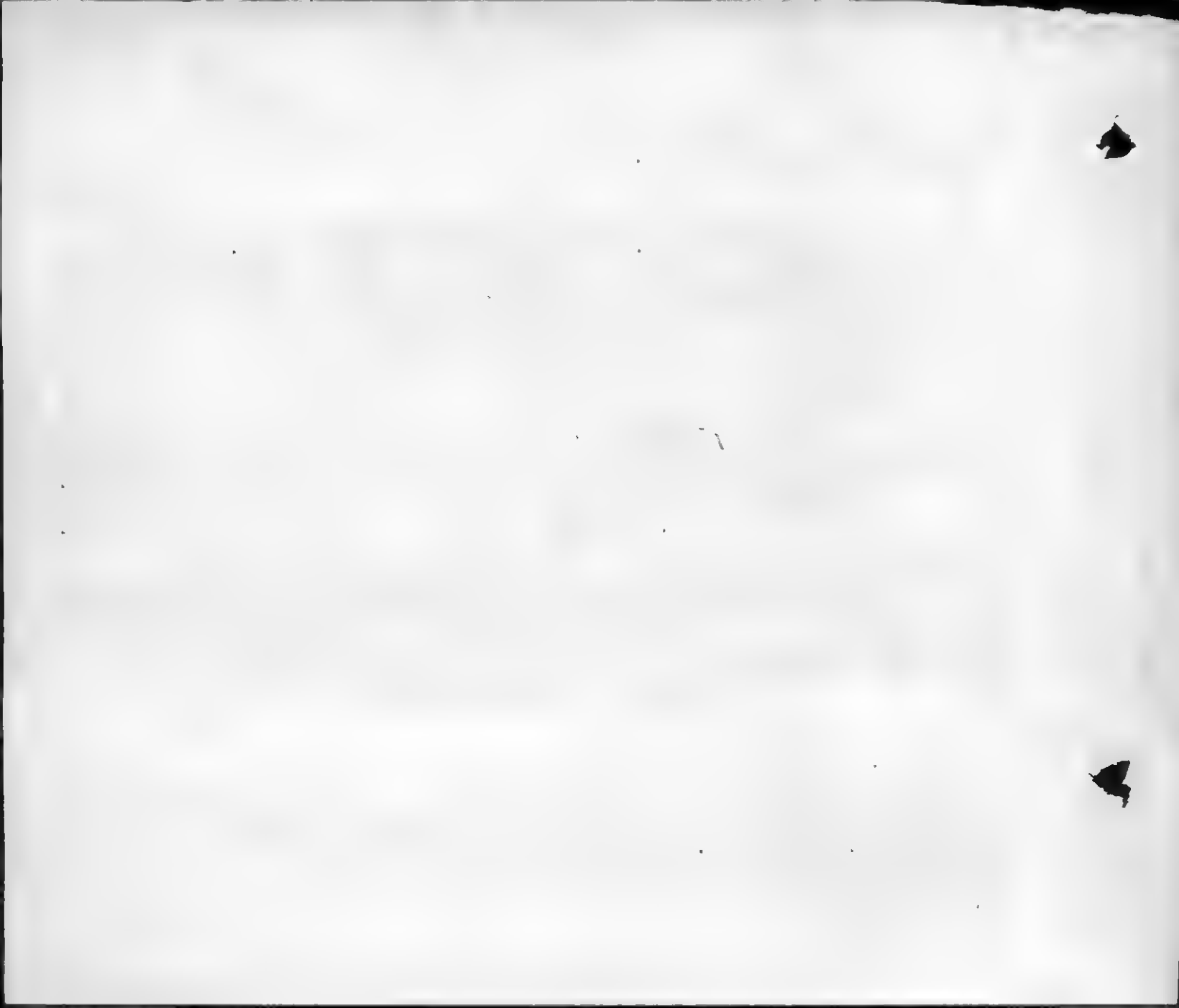
13090

CERTIFICATE OF DEATH

13096

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion Station, Maryland</b>	
c. LENGTH OF STAY IN 1b <b>4 mo. 21 days</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>E.</b> Last <b>Miles</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>22</b> Year <b>19 58</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 10, 1902</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>	11 BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henry Evans</b>	
14. MOTHER'S MAIDEN NAME <b>Harriett Bell</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>unk</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <b>192-36-5765</b>		17. INFORMANT Address <b>Hospital Records Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinoma</b> <b>170X</b> DUE TO <b>Ca. of Breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>4 yrs.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>19</b> Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1, 19 58</b> to <b>Nov. 22, 19 58</b> , that I last saw the deceased alive on <b>Nov. 22, 19 58</b> , and that death occurred at <b>6:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>11/23/58</b>			
ACTUAL SIGNATURE <b>L. Maldve</b>		M.D. <b>Salisbury, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>L. Maldve, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11-25-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MT. PARIAN CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>MARION STATION, MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Stewart</b>		ADDRESS <b>FUNERAL HOME, Salisbury, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Harris</b>	



13091

## CERTIFICATE OF DEATH

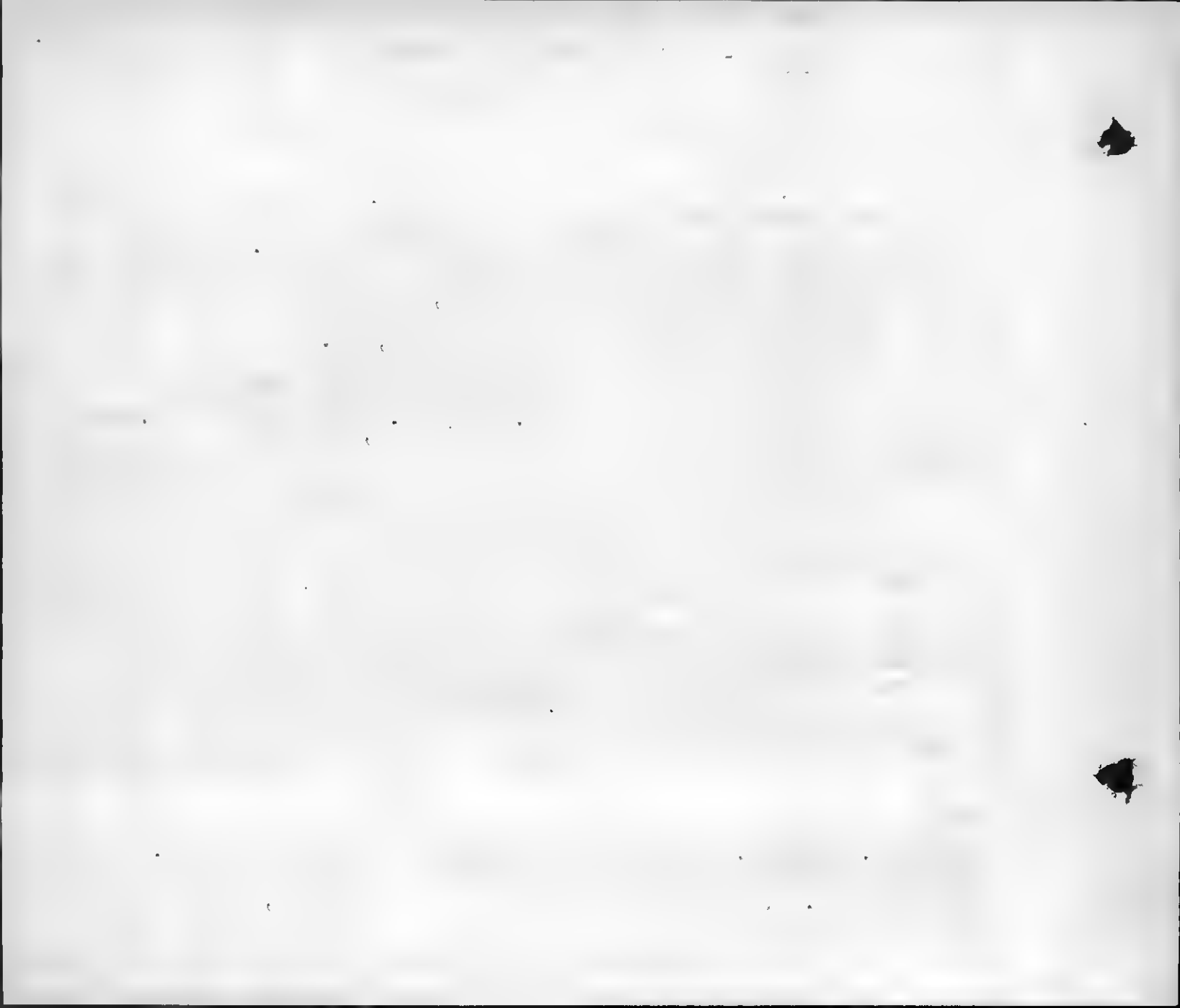
Reg. Dist. No.

13097

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b> <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>520 E. Church St</b>		d. STREET ADDRESS <b>520 E. Church St</b>	
3 NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>WESLEY</b> Last <b>MILLS</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>19th</b> Year <b>58</b>	
5. SEX <b>Male</b> <del>Female</del>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1869</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR: Months <b>8</b> Days <b>19</b> Hours <b>58</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11 BIRTHPLACE (State or foreign country) <b>Quantico, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13 FATHER'S NAME <b>Isaac Mills</b>		14 MOTHER'S MAIDEN NAME <b>Charlotte Anne Jenkins</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <b>INFORMANT</b>	
17 INFORMANT <b>Mrs. Annie H. Mills (Wife)</b>		Address <b>520 E. Church St Salisbury, Maryland</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial Infarction</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2/15, 1954</b> to <b>death</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/17, 1958</b> , and that death occurred on <b>11/19/58</b> at <b>4:30 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ernest M. Larmore</b> M.D.		ADDRESS (Street, city or town, state) <b>1000 West Delmar, Del.</b> DATE SIGNED <b>11/19/58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Ernest M. Larmore</b>		<b>Delmar, Delaware</b> <b>Nov. /1958</b>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 21, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mardela Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Mardela, Maryland</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>NOV 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. S. HARRIS</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13092

## CERTIFICATE OF DEATH

13698

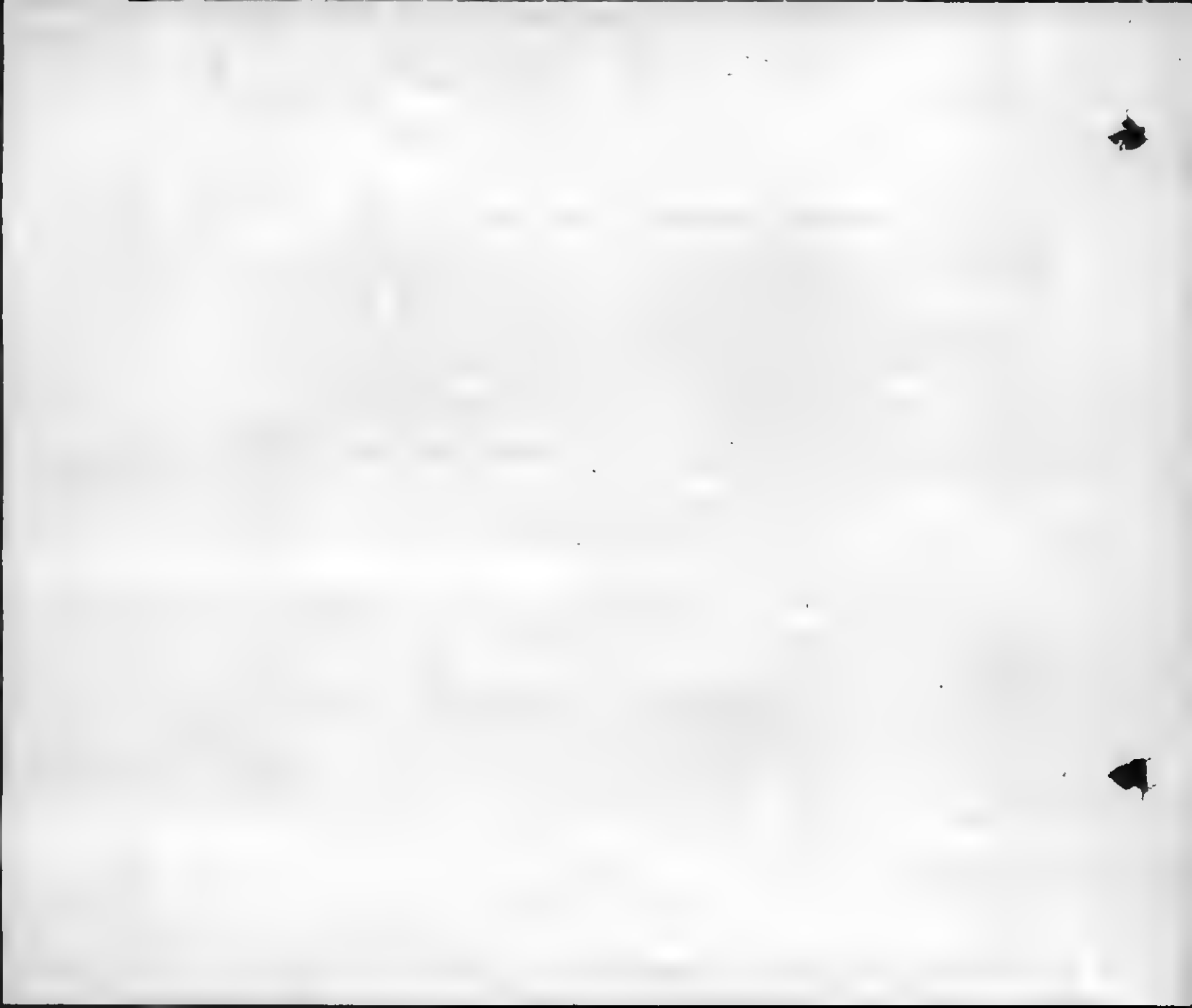
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>9 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Worcester General Hospital</u>		d. STREET ADDRESS <u>SNOW HILL</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ERNEST NICHOLSON</u>		4. DATE OF DEATH <u>NOVEMBER 9 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5 - 1885</u>
9. AGE (In years last birthday) <u>73 1/2</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Policeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City of Berlin, Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Norfolk, Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Isaac Nicholson</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Lamb</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>217-10-2491</u>	
17. INFORMANT <u>Mrs. Ruth Y. Steiner, Berlin, Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Contusion of left hip</u>		INTERVAL BETWEEN ONSET AND DEATH <u>One hr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 7</u> , 19 <u>58</u> , to <u>Nov. 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 7</u> , 19 <u>58</u> , and that death occurred at <u>10:45</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David H. Steiner</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>Nov. 9, 1958</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 11/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Berlin Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Dennis</u>		ADDRESS <u>Snow Hill, Md</u>	
24a. REC'D BY REGISTRAR <u>NOV 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>C. J. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Film 62-1173/59-mb

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) a. STATE <b>Virginia</b> <span style="float: right;">b. COUNTY <b>Accomac</b></span>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b <b>2 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parksley - rural</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Margaret</b> Middle <b>MILLER</b> Last <b>Nock</b>				<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>15</b> Year <b>19 58</b>				
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>DEC. 27, 1921</b>		<b>9. AGE</b> (In years last birthday) <b>36</b> yrs.	<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>Howard Miller</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Annie</b>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service)		<b>INFORMANT</b> <span style="float: right;">Address</span> <b>J. Graham Nock, Parksley, Va.</b>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma Cervix, Epidermoid</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized metastasis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that I attended the deceased from</b> <b>Nov. 14</b> , 19 <b>58</b> , <b>to</b> <b>Nov. 15</b> , 19 <b>58</b> , <b>that I last saw the deceased alive on</b> <b>Nov. 15</b> , 19 <b>58</b> , <b>and that death occurred at</b> <b>6:45 PM</b> , <b>from the causes and on the date stated above.</b> <b>ADDRESS</b> (Street, city or town, state) <span style="float: right;"><b>DATE SIGNED</b></span>								
<b>ACTUAL SIGNATURE</b> <i>Robert Lee Baker</i> M.D.				<b>PHYSICIAN'S NAME</b> (Type) <b>Robert Lee Baker, Salisbury, Maryland</b> <span style="float: right;"><b>11/17/58</b></span>				
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>Nov. 17, 1958</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Parksley</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Parksley, Va.</b>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>John Johnson, Inc.</i> <span style="float: right;"><b>ADDRESS</b></span>				<b>24a. REC'D</b> <b>NOV 25 1958</b> <span style="float: right;"><b>REGISTRAR'S SIGNATURE</b></span>				
<b>John Johnson, Inc., Parksley, Virginia</b>				<b>DATE</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Replacement cert. rec. 11/2/59

Original lost by funeral director  
or postman -

13093

## CERTIFICATE OF DEATH

13093

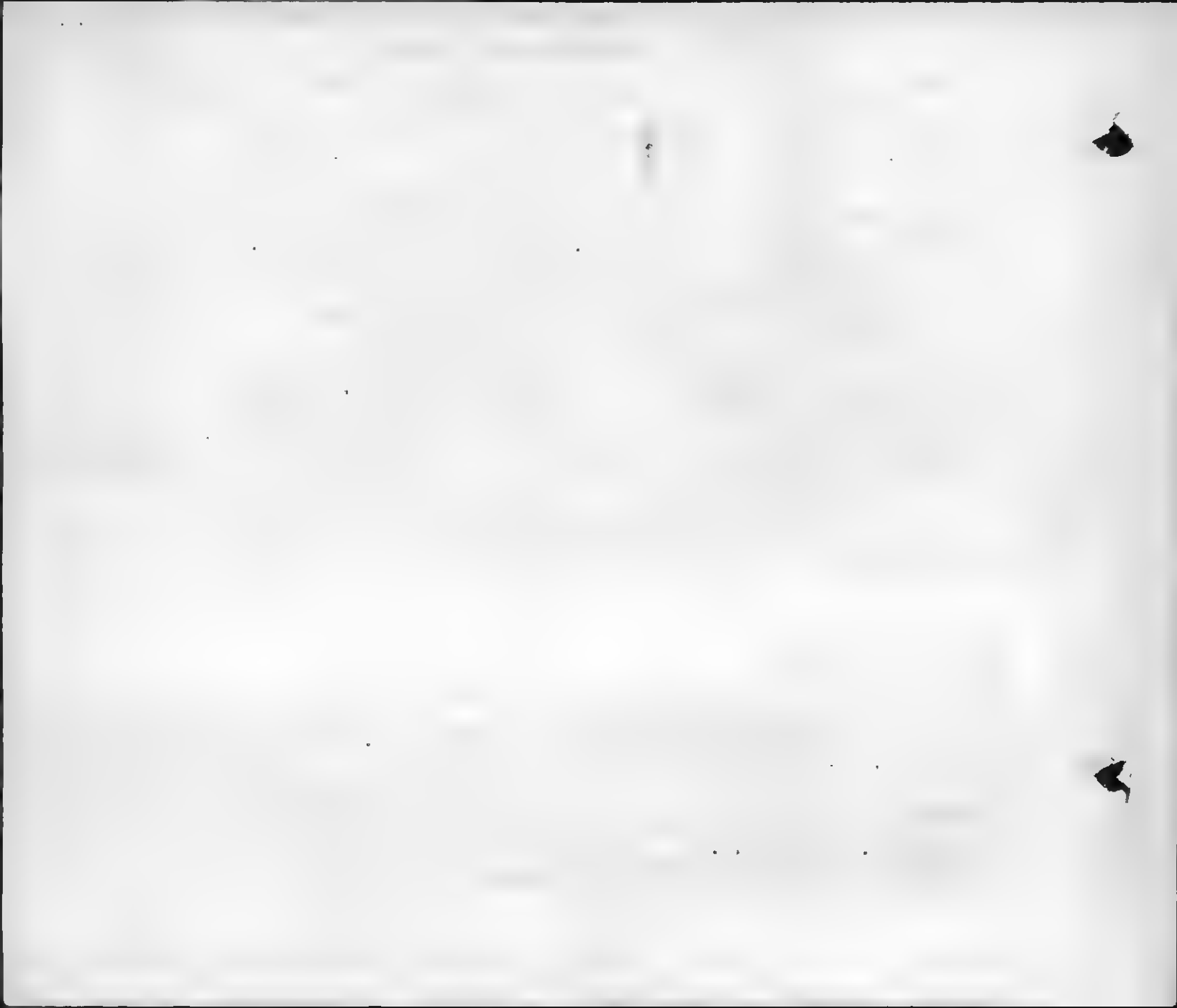
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City, Maryland</b>	
c. LENGTH OF STAY IN 1b <b>6yrs 3 mo 16 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>501 Market Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Amelia</b> Middle <b>C.</b> Last <b>Powell</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>9</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 3, 1872</b>
9. AGE (In years last birthday) <b>86</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John Sidney Bevans</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta B. Clayville</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Hospital Records</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterioscl. cardiovas. disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arterioscl. gen.</b> DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <b>19</b> Month <b>11</b> Day <b>11</b> Year <b>58</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Salisbury, Maryland</b>		(County) (State)	
21. I certify that I attended the deceased from <b>July 23, 19 52</b> to <b>Nov. 9, 19 58</b> , that I last saw the deceased alive on <b>Nov. 9, 19 58</b> , and that death occurred at <b>6:15 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>11/9/58</b>			
ACTUAL SIGNATURE <b>L. Maldve, M.D.</b>		M.D. <b>Salisbury, Maryland</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-11-58</b>	22c. NAME OF CEMETERY <b>Bethany Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry R. Watson</b>		ADDRESS <b>Pocomoke City, Md.</b>	24b. REGISTRAR'S SIGNATURE <b>Crispin L. Hines</b>
24a. REC'D BY REGISTRAR <b>NOV 13 '58</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13094

# CERTIFICATE OF DEATH

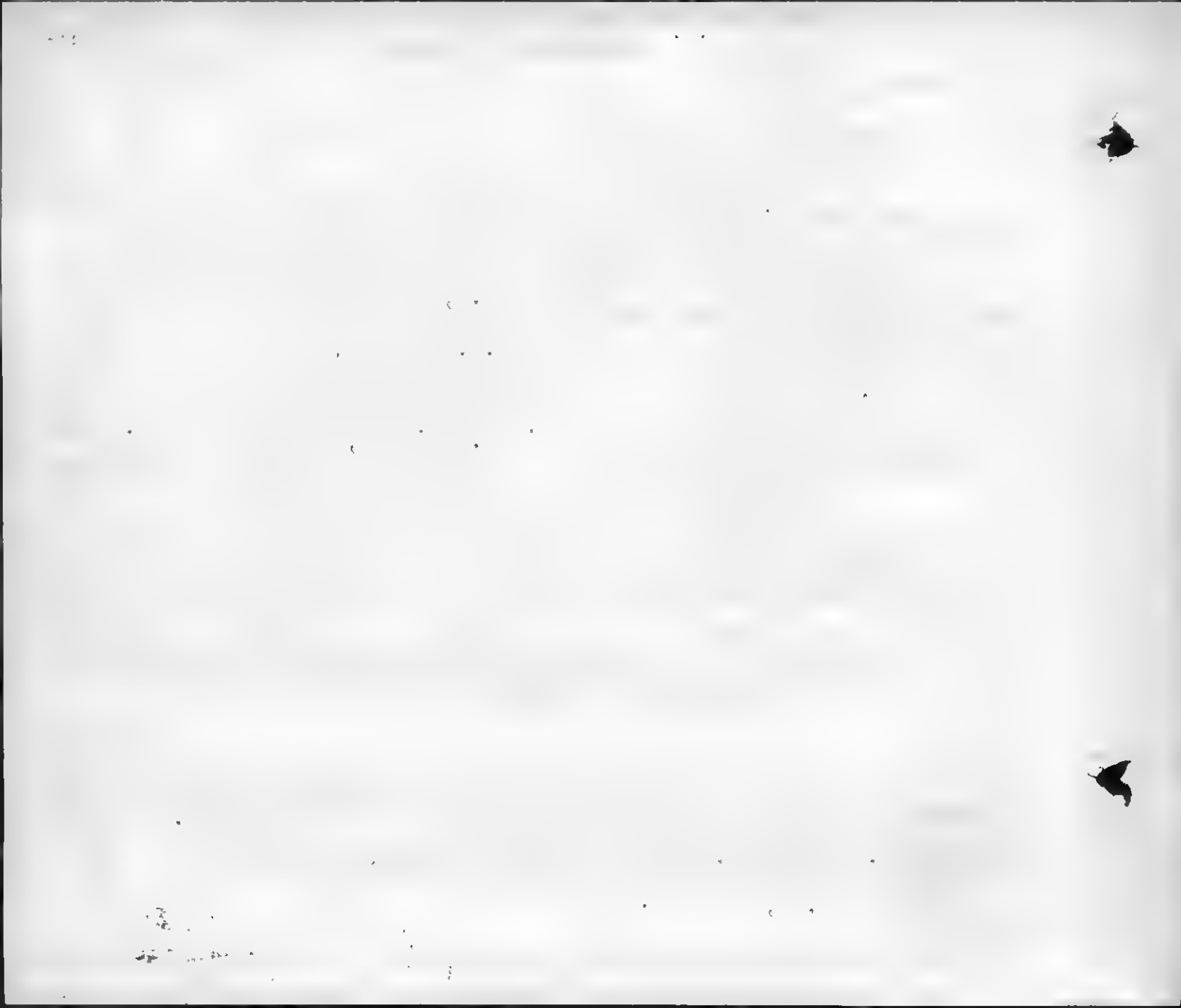
13100

Reg. Dist. No. \_\_\_\_\_

1. PLACE OF DEATH o COUNTY		Wicomico		MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) o STATE		Maryland		b COUNTY		Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c LENGTH OF STAY IN 1b				c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
Salisbury				7 wks				X Delmar				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						/d STREET ADDRESS									
Pen Gen. Hospital						203 Pine St									
3 NAME OF DECEASED (Type or print)		First		Middle		Last		4 DATE OF DEATH		Month		Day Year			
		DORA		ELIZABETH		PUSEY		NOVEMBER		22nd		19 58			
5. SEX		6. COLOR OR RACE		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8 DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		June. 7, 1879		79 yrs.		Months Days		Hours Min.			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
House Work at Home				None				R.D.# Delmar, Maryland				U S A			
13 FATHER'S NAME						14 MOTHER'S MAIDEN NAME									
Major C. Williams						Mariah Elizabeth Parker									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv)				16 SOCIAL SECURITY NO		17. INFORMANT Address									
No						Mrs. James P. Muir (Daughter) 500 N. Bradford St. Dover, Delaware									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Malignant tumor &amp; anemia.</u>															
DUE TO															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinomatosis of abdomen &amp; pleura.</u>															
DUE TO															
(c) <u>Adenocarcinoma of the ovary.</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>3-31</u> , 195 <u>6</u> , to <u>Nov. 22</u> , 195 <u>8</u> , that I last saw the deceased alive on <u>Nov. 22</u> , 195 <u>8</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED															
ACTUAL SIGNATURE <u>Stedman W. Smith</u>				M.D. <u>Nov. 25/1958</u>											
PHYSICIAN'S NAME (Type) <u>Dr. Stedman W. Smith</u>				<u>Salisbury, Maryland</u>											
22a BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)					
<u>Burial</u>				<u>Nov. 25, 1958</u>		<u>Mt. Olive Cemetery</u>				<u>Delmar, Delaware</u>					
23 FUNERAL DIRECTOR'S SIGNATURE						ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
<u>HOLLOWAY &amp; COMPANY</u>						<u>SALISBURY MARYLAND</u>		<u>NOV 26 '58</u>		<u>Arthur L. Knaus</u>					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



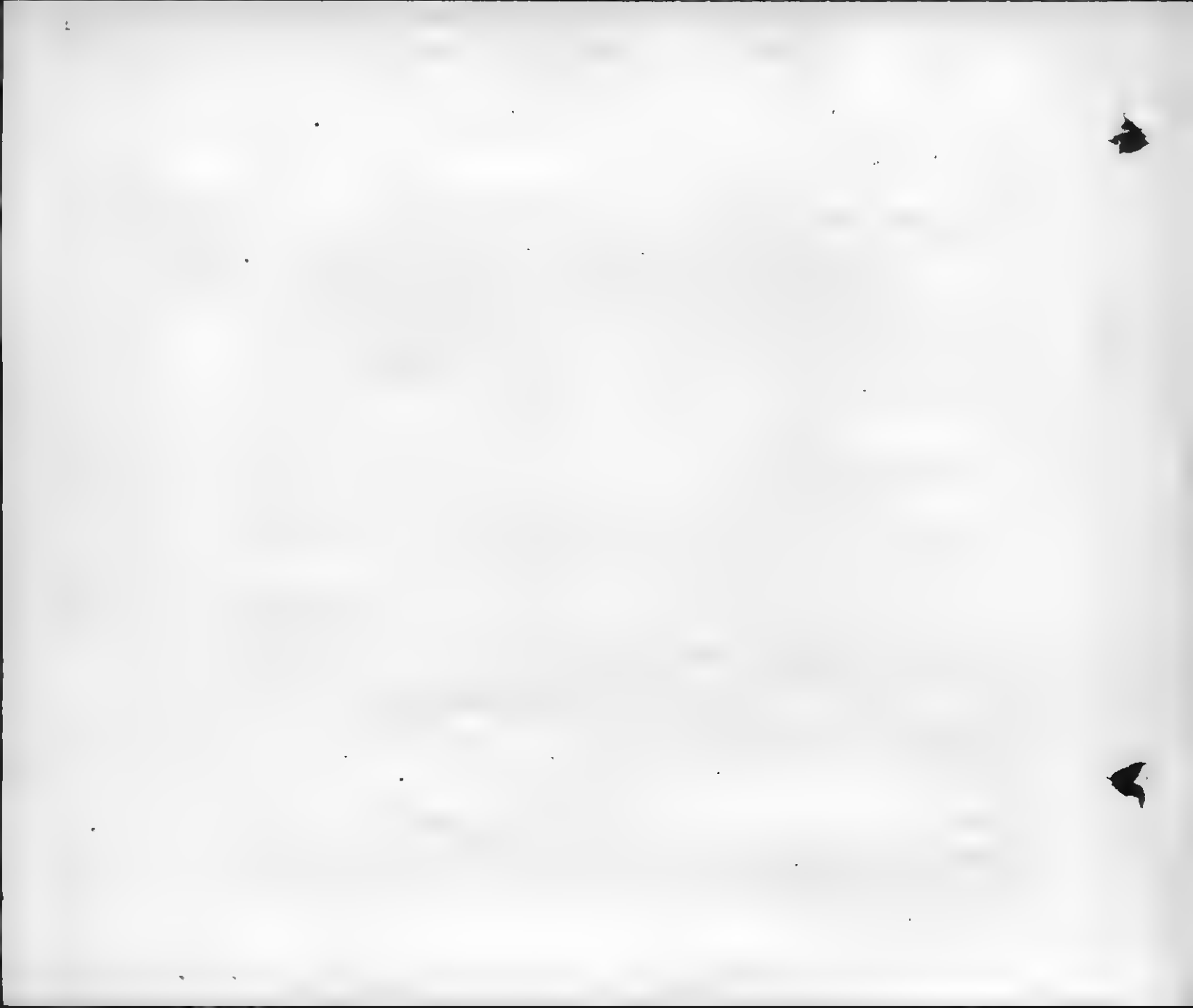
13095

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a COUNTY <u>Allegany</u> <u>100 100</u>		MARYLAND		2. USUAL RESIDENCE [Where deceased lived If institution Residence before admission] a STATE <u>West Virginia</u> b COUNTY <u>Putnam</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Putnam</u>		c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Putnam</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Putnam Hospital</u>		d STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Warman</u> Last <u>Quillin</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 10, 1900</u>	9. AGE (In years last birthday) <u>58</u> yrs	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Robert Quillin</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Honneman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>142</u>		17. INFORMANT <u>Mr. Robert Quillin, Ocean City</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Sarynx with metastasis</u> 161X DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO					
(c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>June 9, 1958</u> to <u>Oct. 5, 1958</u> , that I last saw the deceased alive on <u>June 3, 1958</u> , and that death occurred at <u>4</u> A. M. from the causes and on the date stated above					
ACTUAL SIGNATURE <u>H. Douglas Cooper</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Dr. H. Douglas Cooper</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Livingston</u>	
22d. LOCATION (City, town, or county) <u>Putnam</u>		(State) <u>W. Va.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas H. B. Long</u>		ADDRESS <u>Putnam, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					

VS A15 (4)  
15M 10/57



13096

## CERTIFICATE OF DEATH

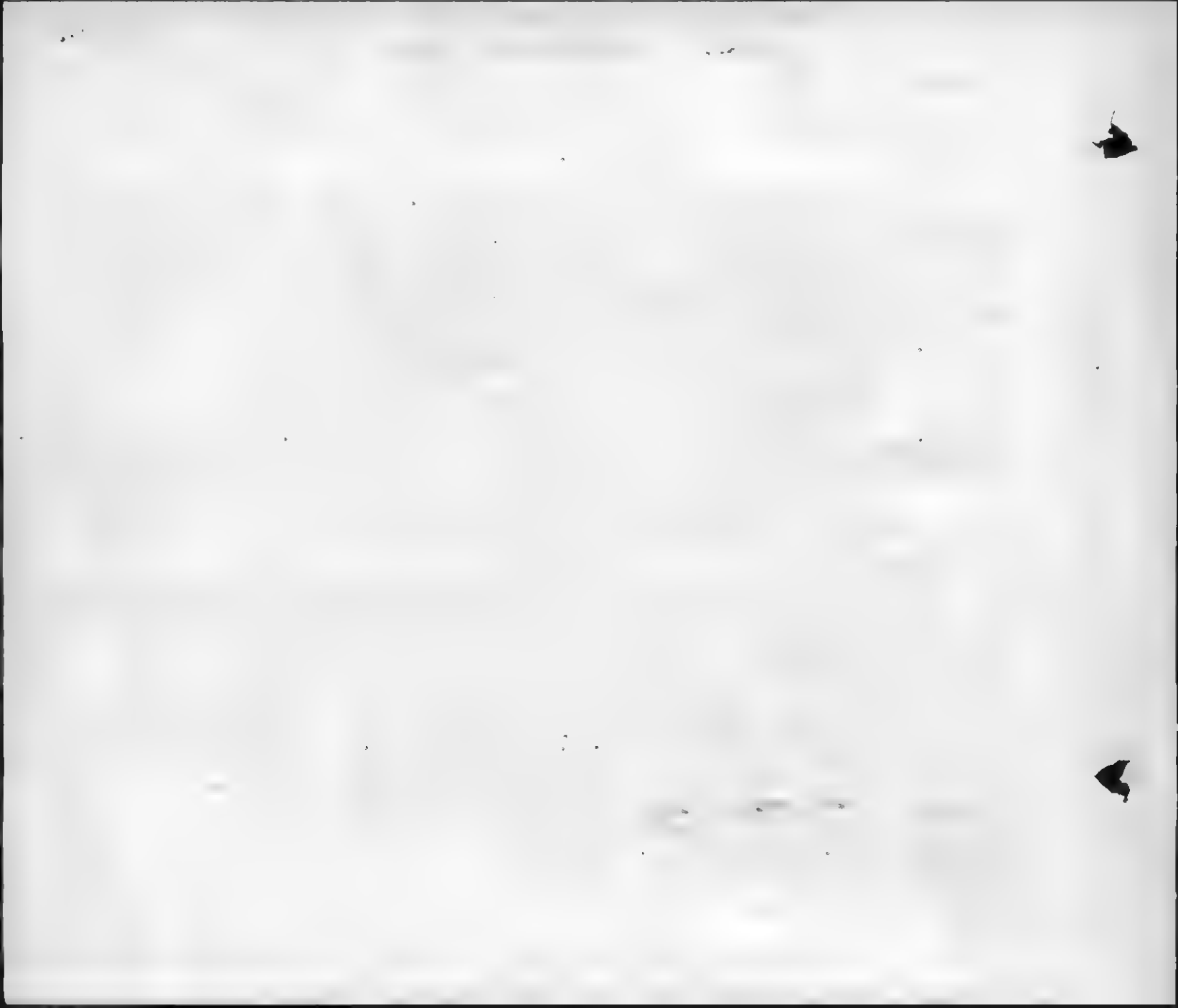
13102

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>2 yrs. 8 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		d. STREET ADDRESS <u>3818 W. Garrison Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u></u> Last <u>Reidmaier</u>		4. DATE OF DEATH Month <u>November</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unk. PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11 BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Karl Reidmaier</u>		14. MOTHER'S MAIDEN NAME <u>Martha (Haveit) Schlauch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO <u>215-05-9979-4</u>	
17 INFORMANT <u>Deer's Head State Hosp. Records, Salisbury, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH Years <u></u> Years <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Residual left hemiplegia; decubiti, multiple.</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 27, 1956</u> , to <u>Nov. 7, 1958</u> , that I last saw the deceased alive on <u>Nov. 7, 1958</u> , and that death occurred at <u>10:30 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Kosmahly</u>		DATE SIGNED <u>11/7/58</u>	
PHYSICIAN'S NAME (Type) <u>G. Kosmahly, M. D.</u>		ADDRESS <u>Deer's Head State Hospital</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-10-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lernard J. Luck</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>	
ADDRESS <u>1305 Harford</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.



13127

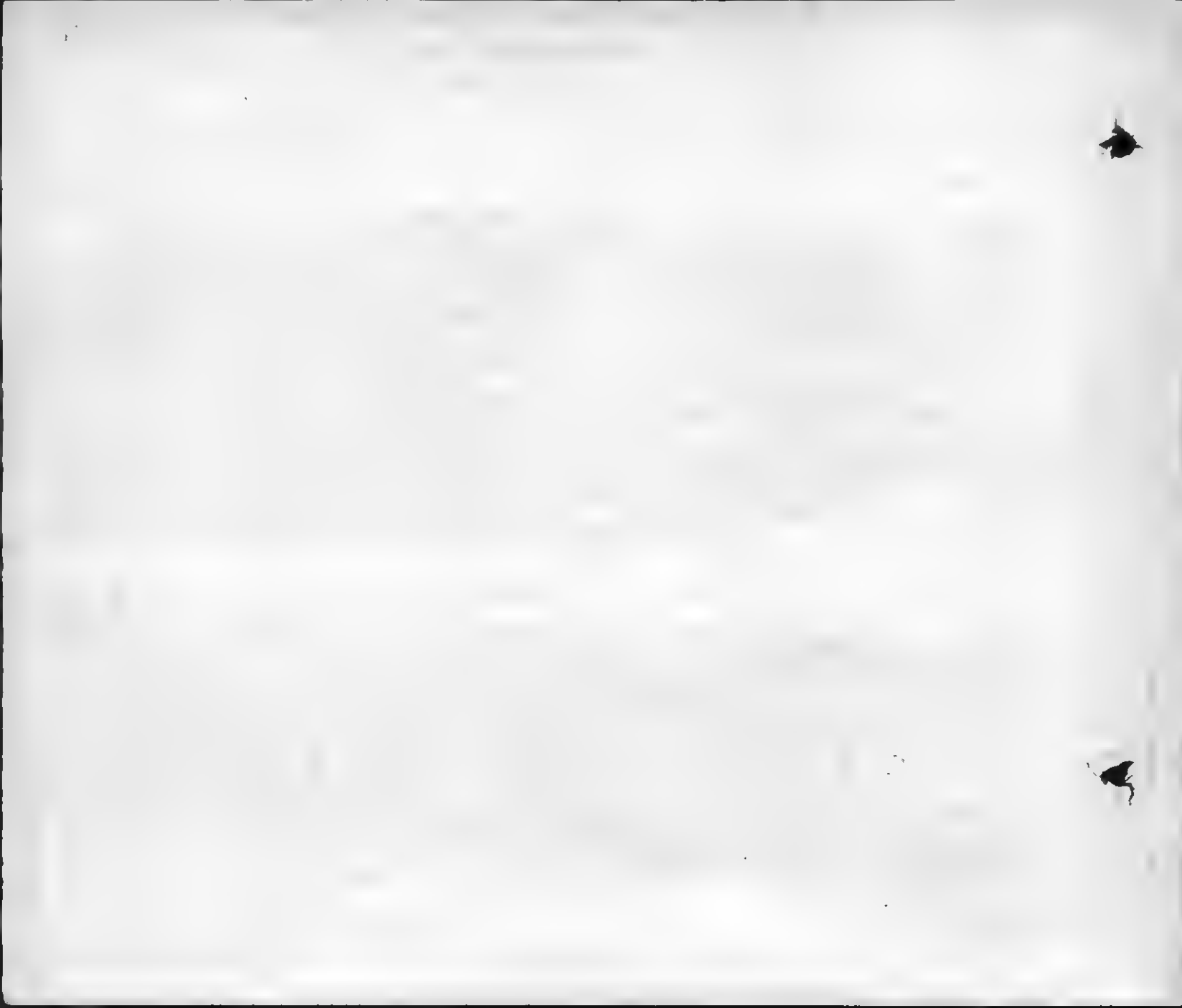
## CERTIFICATE OF DEATH

13103

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jesterville</b>				c. LENGTH OF STAY IN TB <b>Lifetime</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jesterville</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ARTHUR</b> <b>M.</b> <b>RENCHER</b>				4. DATE OF DEATH <b>Nov.</b> <b>3</b> <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/11/1877</b>	9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months <b>4</b> Days <b>22</b> Hours <b>58</b> Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Alpheus Rencher</b>				14. MOTHER'S MAIDEN NAME <b>Annie Robertson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>-----</b>		17. INFORMANT <b>William Rencher, Jesterville, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> DUE TO <b>Generalized Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Atherosclerosis</b> DUE TO <b>Generalized Atherosclerosis</b> (c) <b>Generalized Atherosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b> <b>Broncho pneumonia</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour <b>19</b> Month <b>10</b> Day <b>3</b> Year <b>1958</b> a. m. <b>p. m.</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <b>10 Oct. 1947</b> to <b>3 Nov. 1958</b> that I last saw the deceased alive on <b>3 Nov. 1958</b> , and that death occurred at <b>10 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Richard H. Saunders, M.D.</b>				ADDRESS (Street, city or town, state) <b>Nanticoke Md.</b>			
PHYSICIAN'S NAME (Type) <b>Richard H. Saunders</b>				DATE SIGNED <b>11/4/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/5/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cem.</b>		22d. LOCATION (City, town or county) (State) <b>Jesterville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. J. Messing</b>				ADDRESS <b>Silvale, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 5 58</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. J. Messing</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13128

Item 8 File 216 11-20-58 at

## CERTIFICATE OF DEATH

13104

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Quantico</b> c. LENGTH OF STAY IN 1b <b>Quantico</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home R.F.D. Quantico MD.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Quantico</b> d. STREET ADDRESS <b>R.F.D. #1 Quantico MD.</b> • IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Milton E. Rider</b>		4. DATE OF DEATH Month <b>11</b> Day <b>8</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/25/1936</b>
9. AGE (In years last birthday) <b>21</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Milton E. Rider</b>		14. MOTHER'S MAIDEN NAME <b>Roxie Price</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-34-8363</b>	
17. INFORMANT <b>Milton E. Rider R.F.D. 1 Quantico MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b> <b>471X</b> DUE TO <b>Exposure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Exposure</b> (c) <b>Exposure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>Indefinite</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12:00 58</b> , to <b>8:00 58</b> , that I last saw the deceased alive on <b>8/20/58</b> , 19 <b>58</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>652 W. Main St. Salisbury, Md.</b> DATE SIGNED <b>11/20/58</b> ACTUAL SIGNATURE <b>E. A. Parnell</b> M.D. PHYSICIAN'S NAME (Type) <b>E. A. Parnell, MD. Salisbury, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>11/12/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Quantico Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Hines</b>		24a. REC'D BY REGISTRAR <b>NOV 17 '58</b>	
ADDRESS <b>Salisbury Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

13097 Item 9 11-23-58 11-28-58 et  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

13105

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lincoln General Hospital</u>		d. STREET ADDRESS <u>131 Ervin Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Scott</u> Middle <u>Ross</u> Last <u>Ross</u>		4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1892</u>
9. AGE (In years last birthday) <u>66</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General P</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Ross</u>		14. MOTHER'S MARRIED NAME <u>Rebecca Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. William Ross P. Anne Md</u>	
17. INFORMANT <u>Mr. William Ross P. Anne Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u>Hypertensive Cardiovascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>7 days</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4-73</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb</u> 1958 to <u>Nov 16</u> 1958, that I last saw the deceased alive on <u>Nov 16</u> 1958, and that death occurred at <u>6:05 PM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>B. Frank Giganti</u> M.D.		ADDRESS (Street, city or town, state) <u>20 Prince William V</u>	
PHYSICIAN'S NAME (Type) <u>B. FRANK GIGANTI</u>		DATE SIGNED <u>11/16/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11-19-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oriskany Cemetery</u>	22d. LOCATION (City, town or county) (State) <u>Princess Anne</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon R. Wilson</u> ADDRESS <u>P. Anne Md</u>		24a. REG'D BY REGISTRAR <u>NOV 20 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>



## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13098

## CERTIFICATE OF DEATH

13106

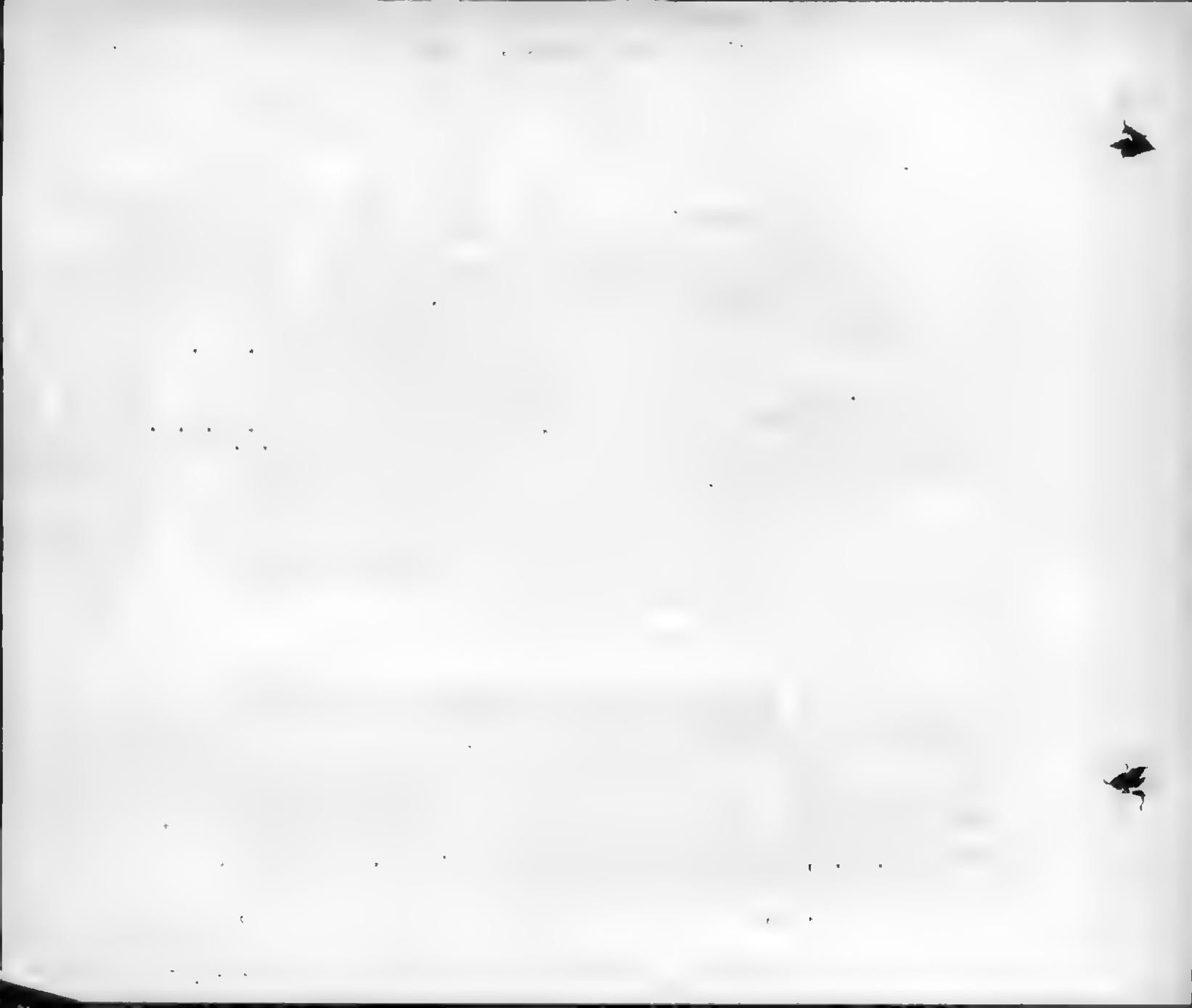
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN IS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 Peninsula General Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Fruitland</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGIE VIRGINIA RYALL</u>		4. DATE OF DEATH Month Day Year <u>November 21 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min <u>8 8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Marion (Worcester Co.) Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William T. Tull</u>		14. MOTHER'S MAIDEN NAME <u>Margaret</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mr. Tull Ryall (Son) 600 F. St. N.W. Washington 4, D.C.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>420.1</u> DUE TO (b) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Atherosclerotic cardiovascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>50 min.</u> <u>55 min.</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/21/1958</u> , to <u>11/21/1958</u> , that I last saw the deceased alive on <u>11/21/1958</u> , and that death occurred at <u>11:27</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Nov. 21, 1958</u>			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D.	
PHYSICIAN'S NAME (Type) <u>Dr. O. J. Burton</u>		<u>Maryland Ave. Salisbury, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 24, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fruitland Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Fruitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>NOV 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

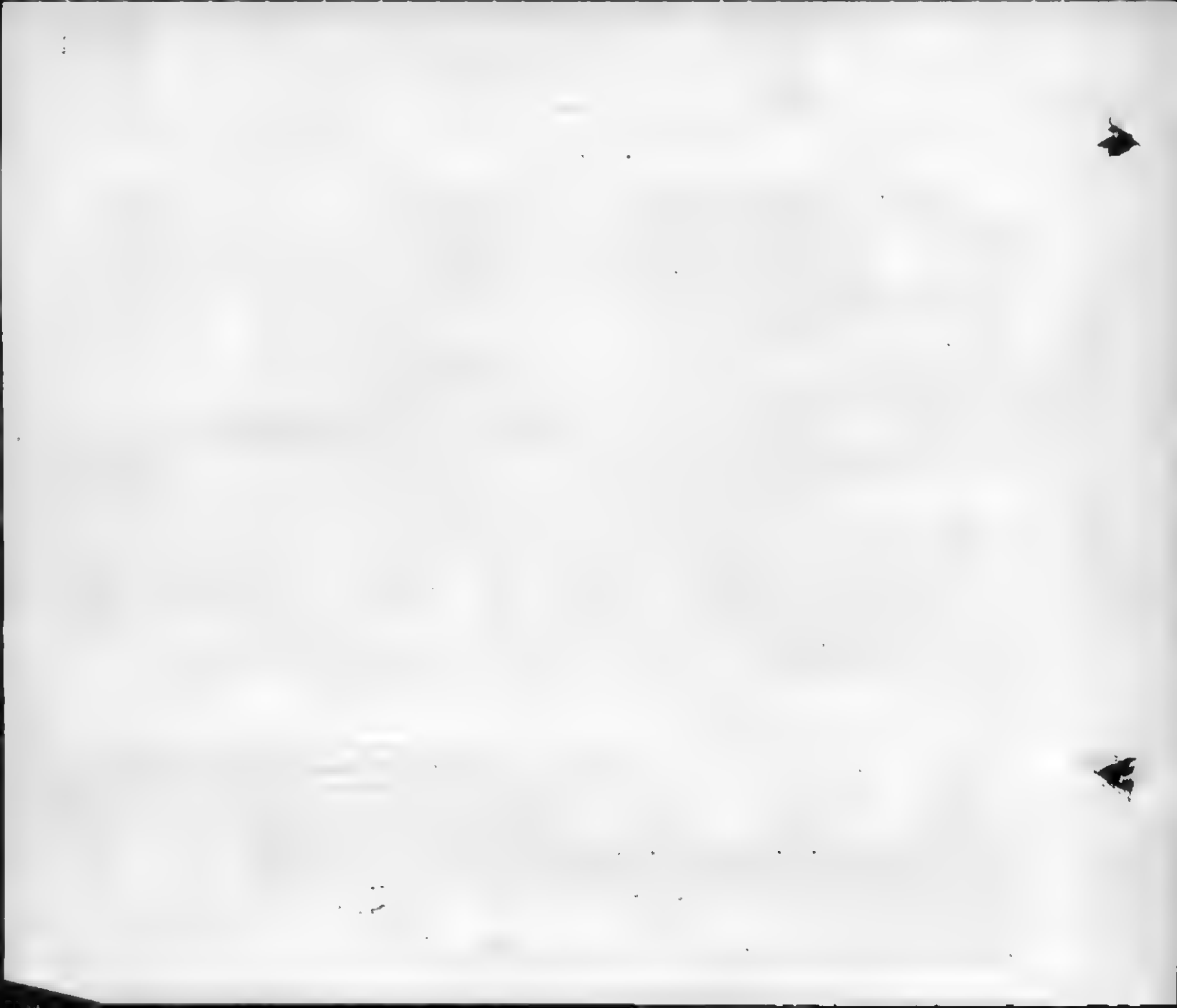
13099

## CERTIFICATE OF DEATH

Reg. Dist. No.

13107

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>2 yr. 3 mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>RFD 3</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ellen</b> Last <b>Shockley</b>		4. DATE OF DEATH Month <b>November</b> Day <b>26</b> Year <b>19 58</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25, 1896</b>	9. AGE (In years last birthday) yrs <b>62</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Handy Bethard</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Foreman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. ---		17. INFORMANT <b>Deer's Head State Hospital Records, Salisbury, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b>							<b>Irs</b>
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) <b>Arteriosclerosis, general</b>							<b>Irs</b>
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <b>August 28, 1956</b> to <b>November 26, 1958</b> , that I last saw the deceased alive on <b>Nov. 26, 1958</b> , and that death occurred at <b>11:05 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i>				ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b>		DATE SIGNED <b>11/26/58</b>	
PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>				Deer's Head State Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-30-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Queen Anne's, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. F. Stewart Funeral Home, Salisbury, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 3 '58</b>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



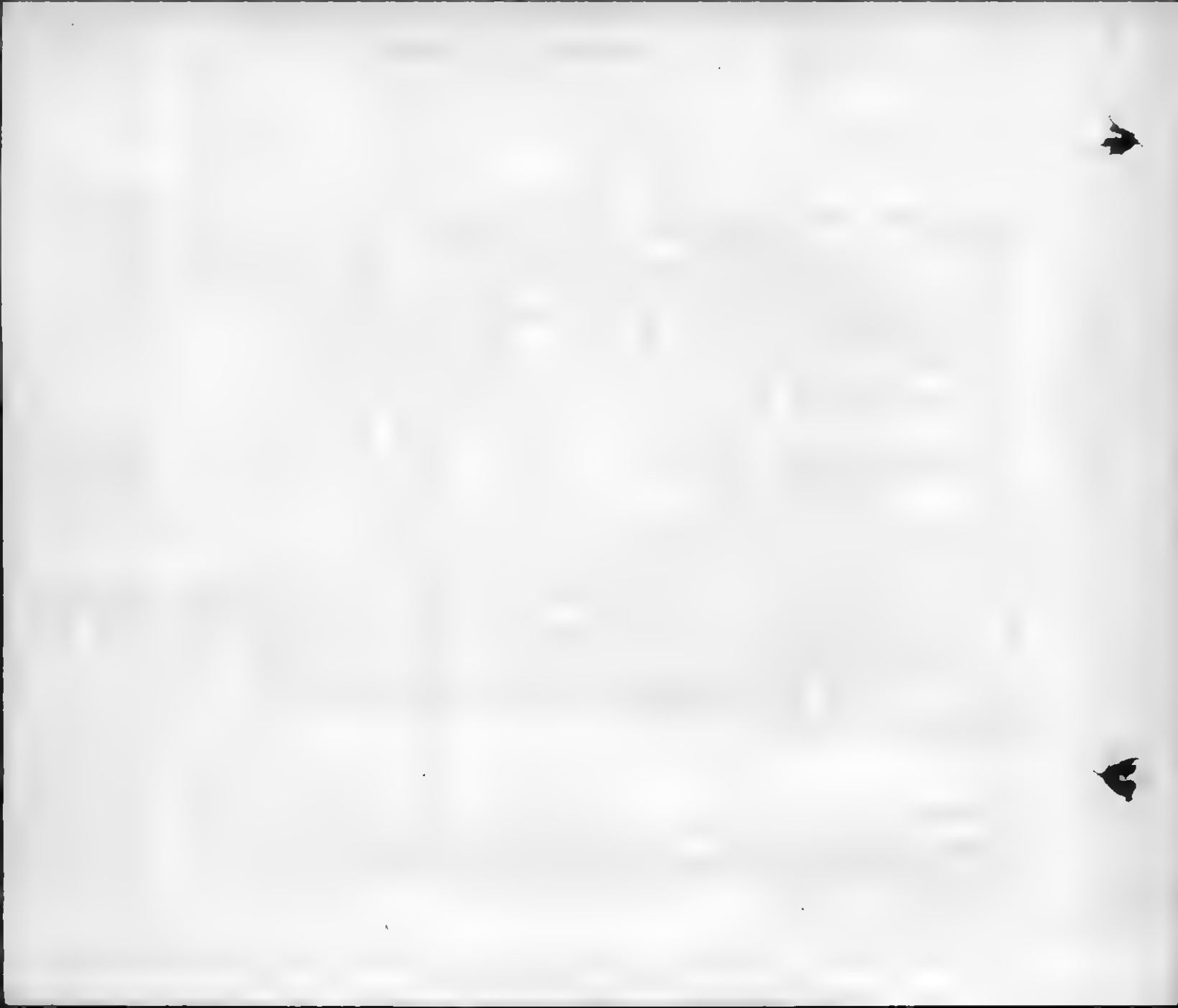
13129

# CERTIFICATE OF DEATH

13108

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharptown</b>				c. LENGTH OF STAY IN 1b <b>20 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Eleanor</b> Last <b>Short</b>				4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 22, 1892</b>	9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min <b>66</b>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Near Freston, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Eskridge</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Carmine</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Wilda H. Short, Sharptown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>531X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>Hypertension</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b> <b>4 years</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <b>Nov 1</b> 19 <b>56</b> , to <b>Nov 20</b> 19 <b>58</b> , that I last saw the deceased alive on <b>Nov 20</b> 19 <b>58</b> , and that death occurred at <b>9:55 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. S. Kuhlman</b>		M.D.		ADDRESS (Street, city or town, state) <b>Sharptown, Md</b>		DATE SIGNED <b>11/24/58</b>	
PHYSICIAN'S NAME (Type) <b>H. S. Kuhlman</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 24, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Galestown Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Galestown, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE REC 1 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	



1

13100

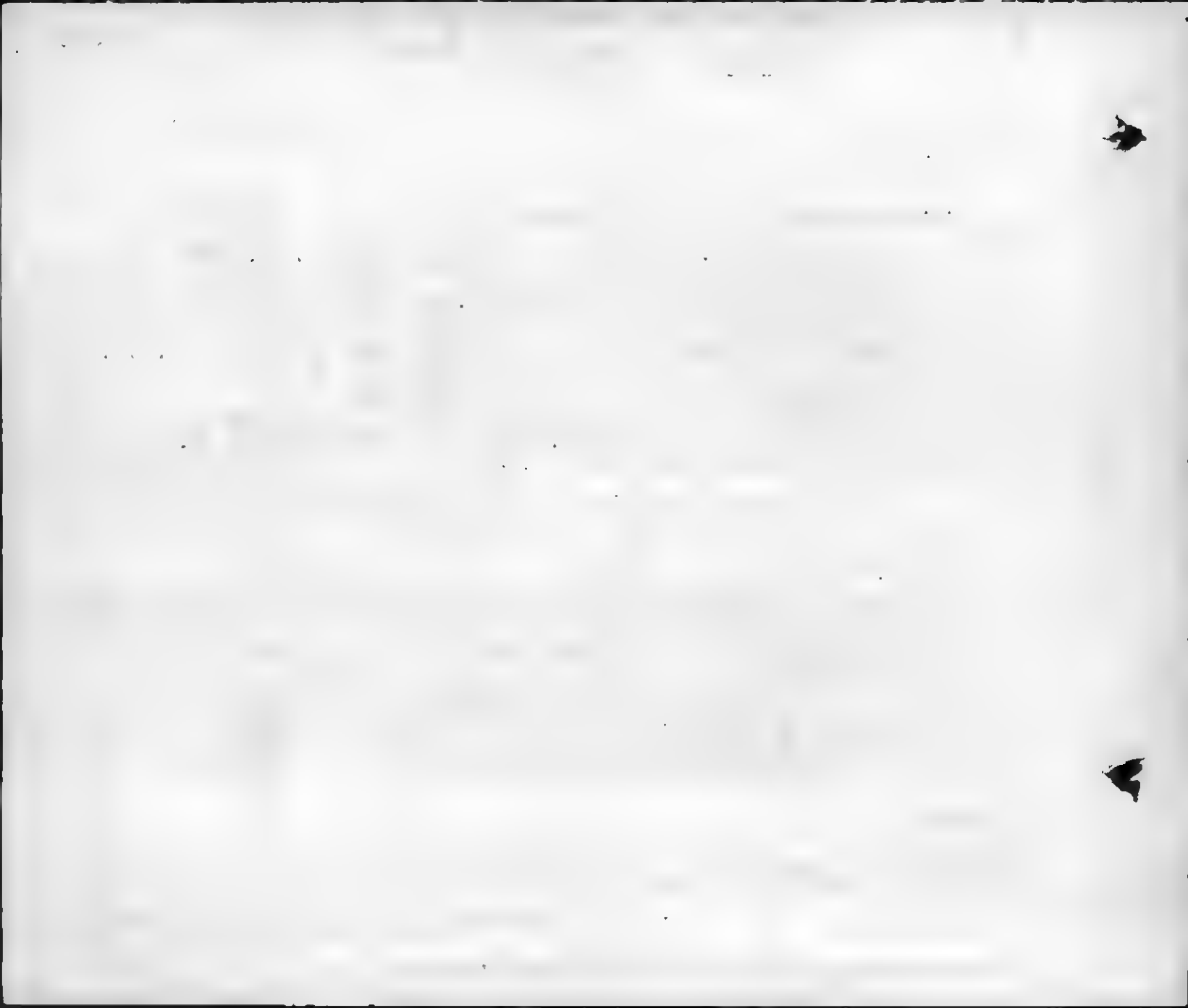
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13109

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>P.G. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Helen E. Smith</b>				4. DATE OF DEATH <b>Nov. 20, 1958</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 22, 1881</b>	
9. AGE (in years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min		19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>			
11. BIRTHPLACE (State or foreign country) <b>New York City</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William DelaRue</b>				14. MOTHER'S MAIDEN NAME <b>Harriett Ripley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		(If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Philip Smith Princess Anne, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause—lost. (b) <b>Hypertensive Cardio Vascular Disease</b> <b>Chronic Nephritis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Chronic Rheumatoid Arthritis</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 yrs.</b> <b>1 yr.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>a. m.</b> Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1955</b> to <b>Nov 20, 1958</b> , that I last saw the deceased alive on <b>Nov 20, 1958</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B. Frank Giganti</b> M.D.				ADDRESS (Street, city or town, state) <b>20 Prince William St Princess Anne, Md.</b>			
PHYSICIAN'S NAME (Type) <b>B. FRANK GIGANTI</b>				DATE SIGNED <b>Nov 24 1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>11-21-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Andrew Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leon R. Wilson</b>				ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 7 4 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>7 4 '58</b>							



13101

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Accomac</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomac</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN TB <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pocomoke General Hospital</u>		d. STREET ADDRESS <u>New Church 83X 4</u>	
3. NAME OF DECEASED (Type or print) <u>Henrietta</u> First <u>Smith</u> Middle <u>Smith</u> Last		4. DATE OF DEATH <u>November 19</u> 19 <u>58</u> Month <u>19</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 17 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>GEORGE WILLIAMS</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA ANNIE MCCREARY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>MRS ARNOLD SPARROW</u>		Address <u>NEW CHURCH, VA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anteriosclerotic Cardiovascular Dis</u> (c) <u>Yes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			INTERVAL BETWEEN ONSET/AND DEATH <u>4 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/15</u> 19 <u>58</u> to <u>11/19</u> 19 <u>58</u> that I last saw the deceased alive on <u>11/19</u> 19 <u>58</u> , and that death occurred at <u>10:55</u> P. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>PINEBLUFF Rd. SALISBURY, Md.</u> DATE SIGNED <u>11/19/58</u>			
ACTUAL SIGNATURE <u> Rufus S. Gardner JR.</u>		PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER JR.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-23-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SALEM METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Watson</u>		ADDRESS <u>POCOMOKE CITY, MD.</u>	
24a. REC'D BY REGISTRAR <u>NOV 24 58</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

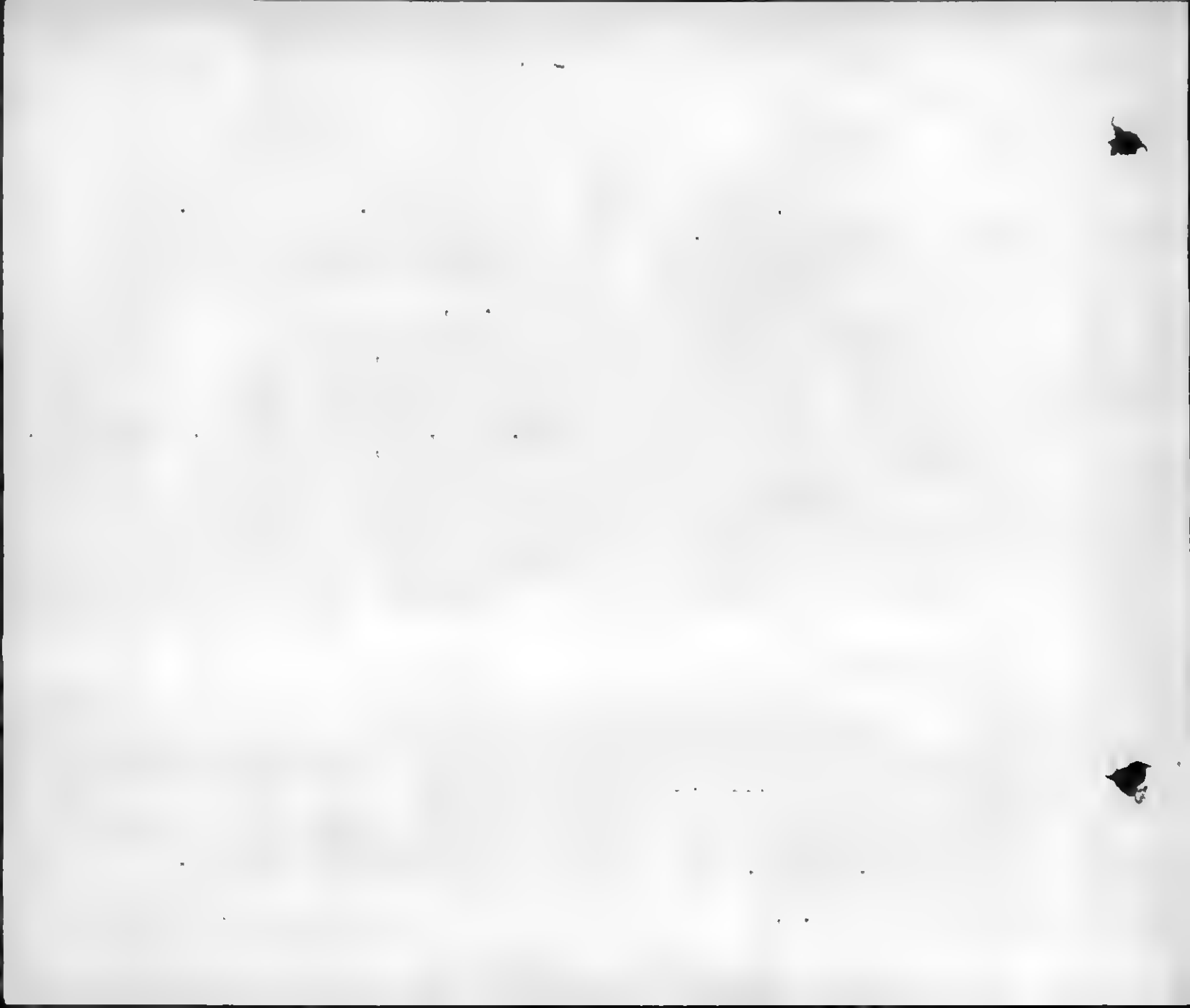
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13102 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13111

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b> <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>411 E. E. Lincoln Ave</b>		d. STREET ADDRESS <b>411 E. Lincoln Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>JOHNNIE HENRY THOMAS SMITH</b>		4. DATE OF DEATH <b>November 4th, 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 24, 1913</b>
9. AGE (in years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic (Quillin-Valliant)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Salisbury, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Harrison Smith</b>		14. MOTHER'S MAIDEN NAME <b>Rosa Esther Niblett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO <b>Informant</b>	
17. ADDRESS <b>411 E. Lincoln Ave. Salisbury, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary occlusion</b> <b>Sudden</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Nov. 6 /1958</b>	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 7, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>NOV 10 1958</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Thayer</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the ward "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

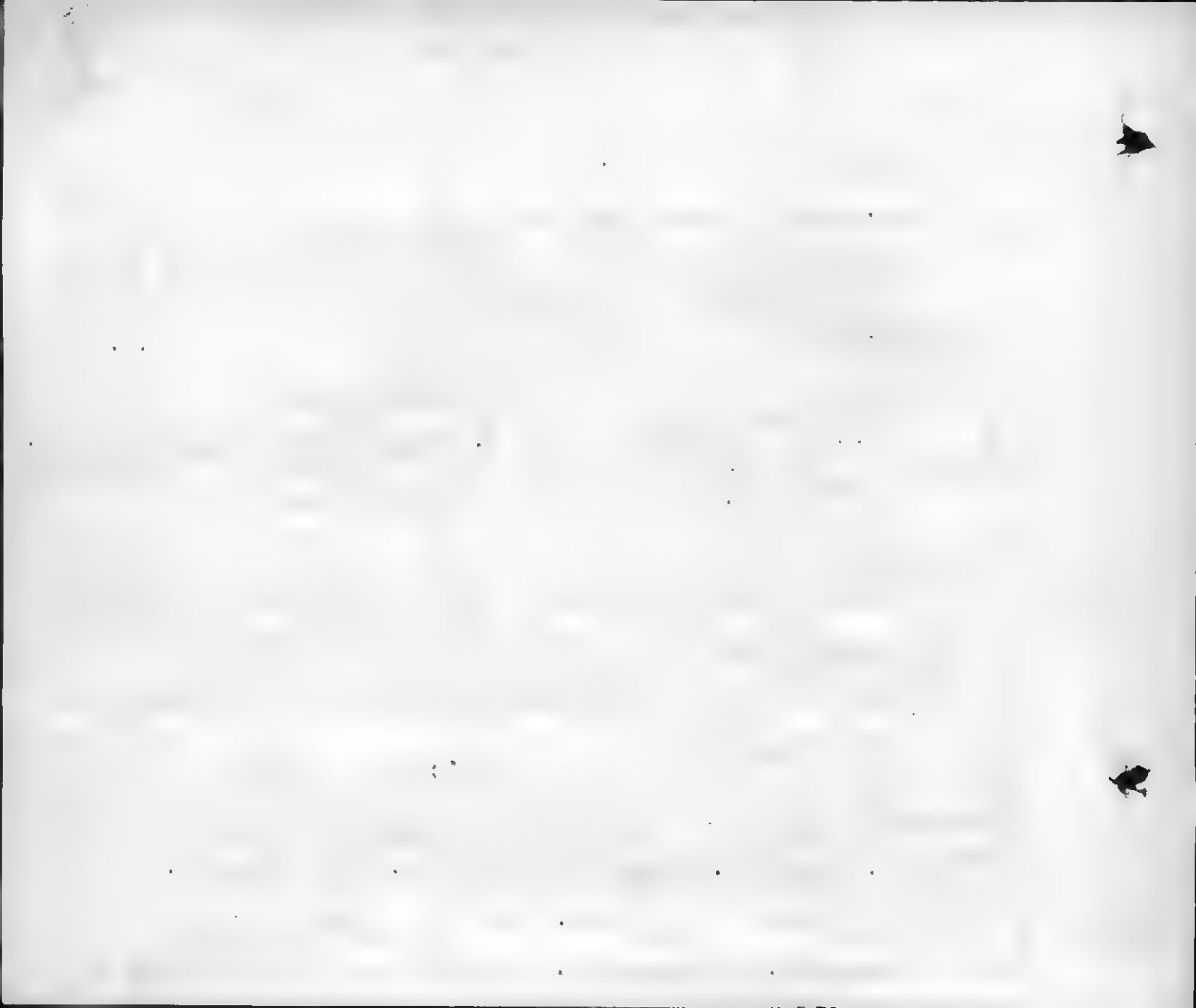
13103

CERTIFICATE OF DEATH

Reg. Dist. No.

13112

1. PLACE OF DEATH o COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE <b>Delaware</b> b. COUNTY <b>Sussex</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>	
c. LENGTH OF STAY IN 1b <b>15 Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>John B. Parsons Home of Age</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MINNIE</b> Middle <b>CLARK</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>11</b> Day <b>15</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 11, 1886</b>
9. AGE (In years at birthday) yrs. <b>78</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ebenzer Clark</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Adkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>John B. Parsons Records, Salisbury, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio-vascular renal disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. st. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-15</b> to <b>11-17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11-15</b> , 19 <b>58</b> , and that death occurred at <b>1:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Phillip A. Insley</b> M.D. <b>Salisbury, Md.</b>		DATE SIGNED <b>11-17-58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Phillip A. Insley, East Main St., Salisbury, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/17/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>First Meth. Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Delmar, Delaware</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co., Salisbury, Md.</b> <b>Norman Baker</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 18 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Robert S. Kraw</b>	



13130

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Main St</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Fruitland</b>			
f. STREET ADDRESS <b>Main St</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>BAPTIST</b> Last <b>STEPHENS</b>				4. DATE OF DEATH Month <b>NOV.</b> Day <b>6th</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 30, 1880</b>	
9. AGE (In years last birthday) <b>78</b>		10. IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>		11. IF UNDER 24 HRS. Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Shipping Clerk (Shirt Factory Camden, Delaware)</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Camden, Delaware</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Albert Stephens</b>				14. MOTHER'S MAIDEN NAME <b>Liza Doland</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO			
17. INFORMANT <b>Mrs. Elizabeth M. Stephens (Wife)</b>				Address <b>Main St Fruitland, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>331X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour <b>19</b> Month <b>11</b> Day <b>7</b> Year <b>1958</b> a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Nov. 5, 1958</b> to <b>Nov. 7, 1958</b> that I last saw the deceased alive on <b>Nov. 7, 1958</b> , and that death occurred at <b>11:20 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip A. Insley</b> M.D.				DATE SIGNED <b>Nov. 7, 1958</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Philip A. Insley</b> <b>Main St. Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Nov. 9, 1958</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>				22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>			
24a. REC'D BY REGISTRAR <b>NOV 10 1958</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knecht</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13104

## CERTIFICATE OF DEATH

13114

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pleasant Care Home</b>		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>SARAH</b> First <b>A. (Line)</b> Middle <b>SULLIVAN</b> Last		4. DATE OF DEATH Month <b>NOV.</b> Day <b>27th</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 1, 1868</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>9</b> Days <b>26</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Snow Hill, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Peter Livingston</b>		14. MOTHER'S MAIDEN NAME <b>Louiseia Dixon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Mr. Charles V. Livingston (Brother) 210 Wash St. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b> <b>331X</b> DUE TO <b>Senility</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9-20</b> , 19 <b>58</b> , to <b>11-18</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11-18</b> , 19 <b>58</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Nov. 28/1958</b>			
ACTUAL SIGNATURE <b>Dr. O. J. Burton</b>		M.D. <b>Nov. 28/1958</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Andrew C. Mitchell</b>		<b>Maryland Ave. Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 29, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>DEC 2 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Calvin S. K...</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

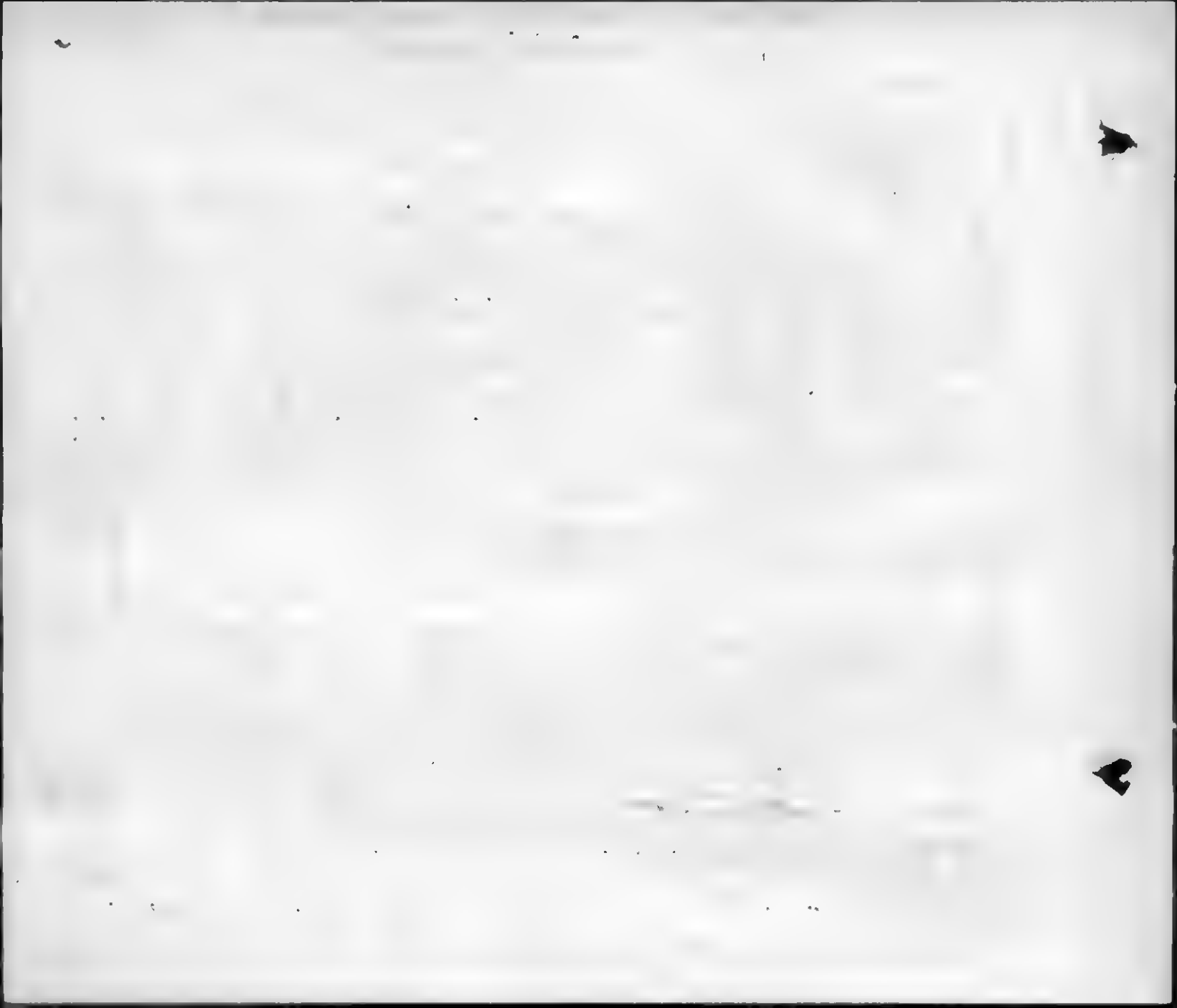
CERTIFICATE OF DEATH

13115

Reg. Dist. No.

13105

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>16 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				f. STREET ADDRESS <b>Rt. 2, Springhill Road</b>			
4. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Harrison</b> Last <b>Tarkenton</b>				4. DATE OF DEATH Month <b>November</b> Day <b>28th</b> , Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 2, 1887</b>		9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Mathias M. Tarkenton</b>				14. MOTHER'S MAIDEN NAME <b>Frances Elizabeth Brickhouse</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unk.</b>				16. SOCIAL SECURITY NO. <b>Deer's Head Hospital Records, Salisbury, Md.</b>			
17. INFORMANT <b>Mrs. Sallie M. Tarkenton (Wife)</b>				18. R.D. # <b>2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor pulmonale</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary emphysema</b> DUE TO (c) <b>Congestive heart failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks ?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>November 12, 19 58</b> , to <b>November 28, 19 58</b> , that I last saw the deceased alive on <b>November 28, 19 58</b> , and that death occurred at <b>2:20A</b> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>G. Kosmahly</b> M.D.				<b>Deer's Head State Hospital 11/28/58</b>			
PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M. D.</b>				<b>Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 1st, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Memory Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 2 58</b>	
				24b. REGISTRAR'S SIGNATURE <b>John S. Hiana</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delayed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13106

CERTIFICATE OF DEATH

Reg. Dist. No.

13116

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Locust Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Teagle</u> Last <u>Teagle</u>				4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/12/1897</u>	
9. AGE (in years last birthday) <u>61</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>							
13. FATHER'S NAME <u>George Teagle</u>				14. MOTHER'S MAIDEN NAME <u>Lanty Showell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes one</u>				16. SOCIAL SECURITY NO <u>219*05-3328</u>		17. INFORMANT <u>Hattie Dennis</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular</u> DUE TO <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 weeks</u> INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8 Oct</u> , 19 <u>58</u> , to <u>8 Nov</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8 Nov</u> , 19 <u>58</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>11 Nov 1958</u> ACTUAL SIGNATURE <u>E. A. Funnell</u> M.D. <u>6:30 PM</u> PHYSICIAN'S NAME (Type) <u>E. A. Funnell M.D. Salisbury, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Acreas</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton H. Stuart</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



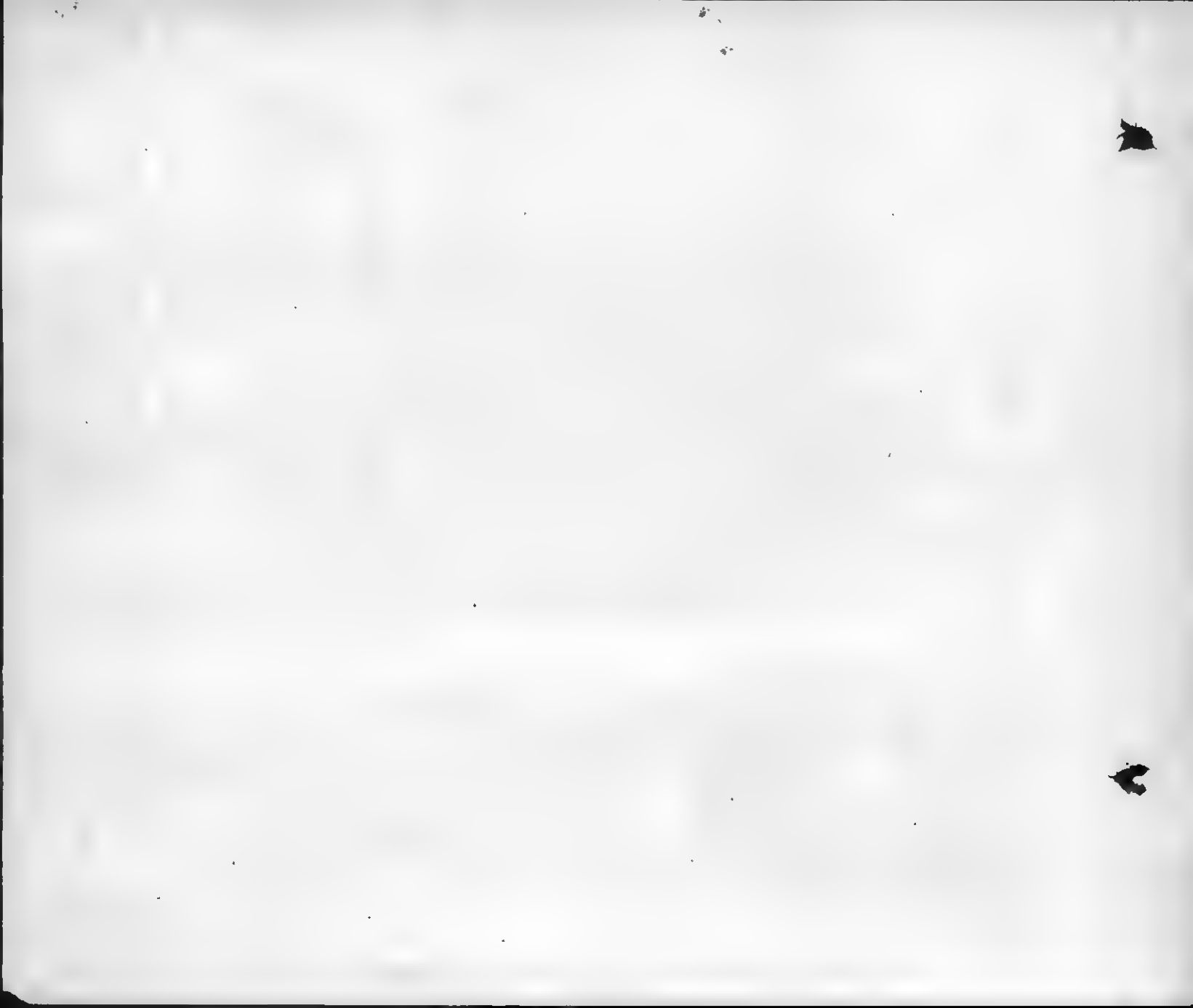
13107

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>19</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsular General Hospital</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Ellen</u> First <u>Thomas</u> Middle Last		4. DATE OF DEATH <u>November 26</u> 19 <u>58</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8, 1895</u> 9. AGE (In years last birthday) <u>63</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Factory</u>	
11 BIRTHPLACE (State or foreign country) <u>Germany</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cummins</u>		14. MOTHER'S MAIDEN NAME <u>Malinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>137-032004</u>	
17. INFORMANT <u>Mr. Freda Robinson</u> Address <u>Lake Road Brookfield, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>430.1</u> DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>Congestive Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19</u> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/21</u> 19 <u>58</u> to <u>11/26</u> 19 <u>58</u> that I last saw the deceased alive on <u>11/26</u> 19 <u>58</u> , and that death occurred at <u>8:50</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Pinebluff Rd. Salisbury, Md.</u> DATE SIGNED <u>11/26/58</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-29-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Miles Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Fairmount Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin B. Wilson</u> ADDRESS <u>Prince Georges Ave. Md.</u>		24a. RECEIVED BY REGISTRAR <u>DEC 2 '58</u> 24b. REGISTRAR'S SIGNATURE <u>C. J. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13108

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Baltimore County</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		c LENGTH OF STAY IN 1b <b>2yrs 8mo 18days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		d STREET ADDRESS <b>Ruxton, Maryland</b>	
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>Belle</b> Last <b>Tingle</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>27</b> Year <b>19 58</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 6, 1870</b>
9. AGE (In years last birthday) <b>88</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>	11 BIRTHPLACE (State or foreign country) <b>Delaware</b>
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Tingle</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Clogg</b>		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>unk</b>	
16 SOCIAL SECURITY NO. <b>unk</b>		17 INFORMANT <b>Hospital Records</b> Address <b>Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO <b>Arteriosclerosis generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis generalized</b> DUE TO (c) <b>Arteriosclerosis generalized</b>			INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>Old cerebral thrombosis</b>			
19. WAS ALTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/8/56</b> , 19 <b>56</b> , to <b>11/27</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/27</b> , 19 <b>58</b> , and that death occurred at <b>9:10 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>11/27/58</b>			
ACTUAL SIGNATURE <b>L. Maldve</b>		M.D. <b>Salisbury, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>L. Maldve, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>12/2/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WEST LAUREL HILL</b>	22d. LOCATION (City, town, or county) (State) <b>BALA-CYNWYD PA.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Watson &amp; Gray Spillars Del.</b>		24a REC'D BY REGISTRAR <b>DEC 1 '58</b>	24b REGISTRAR'S SIGNATURE <b>Arthur L. Knud</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



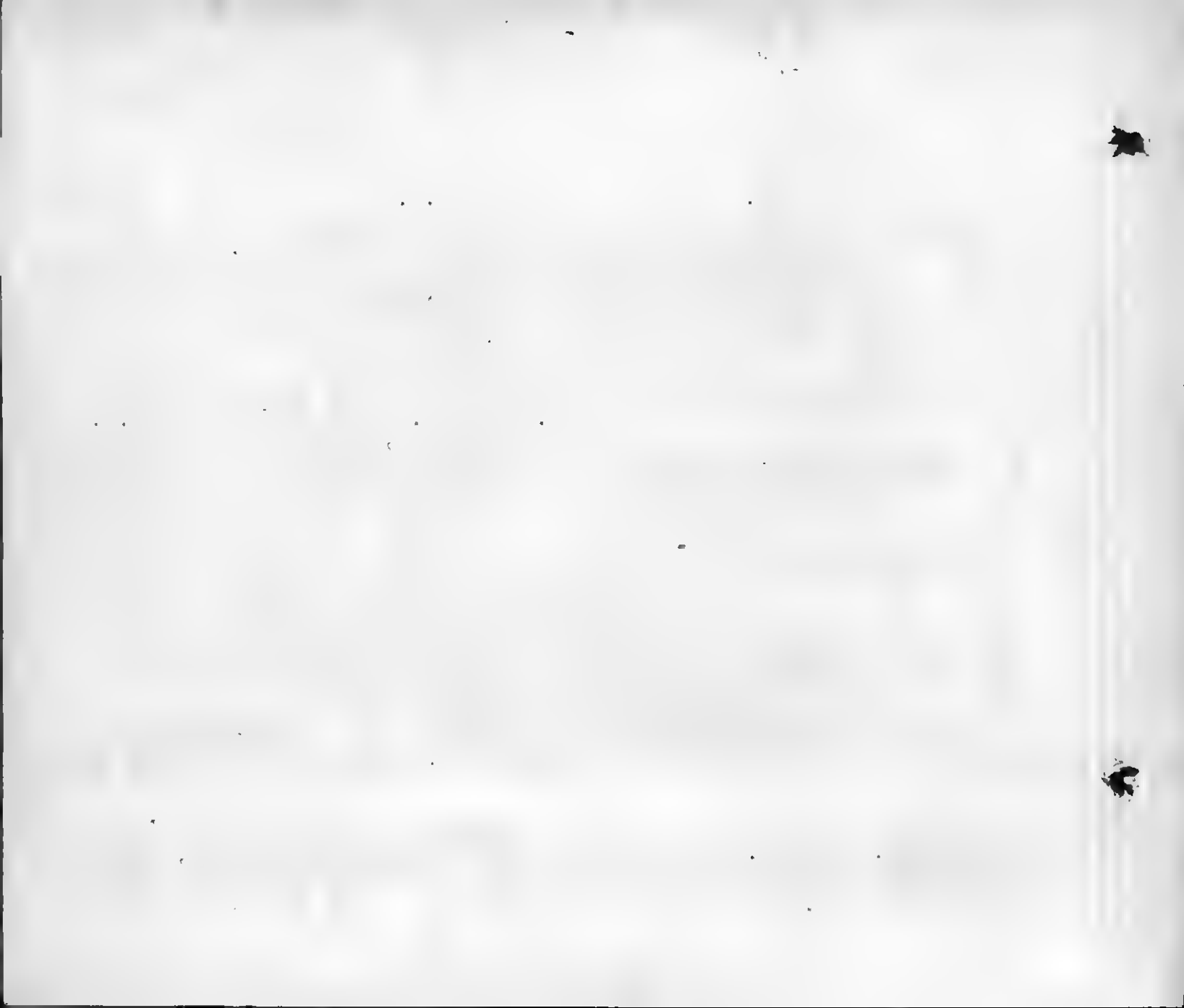
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13109**  
**CERTIFICATE OF DEATH**

**13113**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>Sussex</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>4 x 2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen. Hosp</b>				d. STREET ADDRESS <b>R.D.# 3</b>			
3. NAME OF DECEASED (Type or print) First <b>EDITH</b> Middle <b>L</b> Last <b>UMBENHOUR</b>				4. DATE OF DEATH Month <b>NOV.</b> Day <b>5th</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 5, 1895</b>	
9. AGE (In years last birthday) <b>63 yrs</b>		10. IF UNDER 1 YEAR Month <b>7</b> Day <b>0</b> Hours <b></b> Min. <b></b>		11. IF UNDER 24 HRS Hours <b></b> Min. <b></b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
13. FATHER'S NAME <b>Amose Turner</b>				14. MOTHER'S MAIDEN NAME <b>Bertha (UnKd)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <b>Mr. Edward J. Umbenhour (husband) R.D.# 3 Millsboro, Delaware</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct, acute</b> <b>120.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>11/2, 1958</b> , to <b>11/5, 1958</b> , that I last saw the deceased alive on <b>11/5, 1958</b> , and that death occurred at <b>1:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>Nov. 7 1958</b> ACTUAL SIGNATURE <b>Dr. David J. Gilmore</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. David J. Gilmore</b> <b>Medical Center-Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 10, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parker Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pittsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>NOV 10 58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hous</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or removal, and in any event within 72 hours after death.

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Item 18 Film 236 12-5-58 ams  
13110  
19  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

13120

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALESBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALESBURY</u>			
d. NAME OF HOSPITAL (If not at hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>				d. STREET ADDRESS <u>114 S. DILISICK STREET</u>			
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>L.</u> Last <u>WARD</u>				4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 16 1890</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u> Hours <u>15</u> Mins <u>00</u>		11. IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OCEAN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JAMES + THOMAS WARD</u>				14. MOTHER'S MAIDEN NAME <u>IDA WILKINS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>ARTHUR WARD, LAUREL DEL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>                    </u> DUE TO (c) <u>                    </u>						INTERVAL BETWEEN ONSET AND DEATH <u>25 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Portal cirrhosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>11/2/58</u> to <u>11/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/27</u> , 19 <u>58</u> , and that death occurred at <u>8 A.</u> M., from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Arthur W. Ward</u>				ADDRESS (Street, city or town, state) <u>711 Camden Ave</u>		DATE SIGNED <u>11/28/58</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/31/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Ch. Cem</u>		22d. LOCATION (City, town, or county) (State) <u>NEAR LAUREL DEL</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur W. Ward</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>DEC 2 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>C. E. K. K. K.</u>	



13131

CERTIFICATE OF DEATH

13121

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whitton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whitton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) <u>MANIE</u> First <u>E.</u> Middle <u>WEBB</u> Last		4. DATE OF DEATH <u>Nov.</u> Month <u>20</u> Day <u>1958</u> Year	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 10, 1868</u>
9. AGE (in years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Marsellus Dennis</u>		14. MOTHER'S MAIDEN NAME <u>Laura Powell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Lillian Morris Powell</u>		Address <u>Powellville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 wk.</u> <u>? years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured left hip</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 15, 1958</u> , to <u>Nov. 20, 1958</u> , that I last saw the deceased alive on <u>Nov. 19, 1958</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>104 Bay St. Snow Hill, Md.</u>		DATE SIGNED _____	
ACTUAL SIGNATURE <u>John M. Bender</u> M.D.		PHYSICIAN'S NAME (Type) <u>John M. Bender, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/22/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Dennis</u>		22d. LOCATION (City, town, or county) (State) <u>Powellville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lillian Morris Powell</u>		ADDRESS _____	
24a. REC'D BY REGISTRAR <u>NOV 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Knoch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

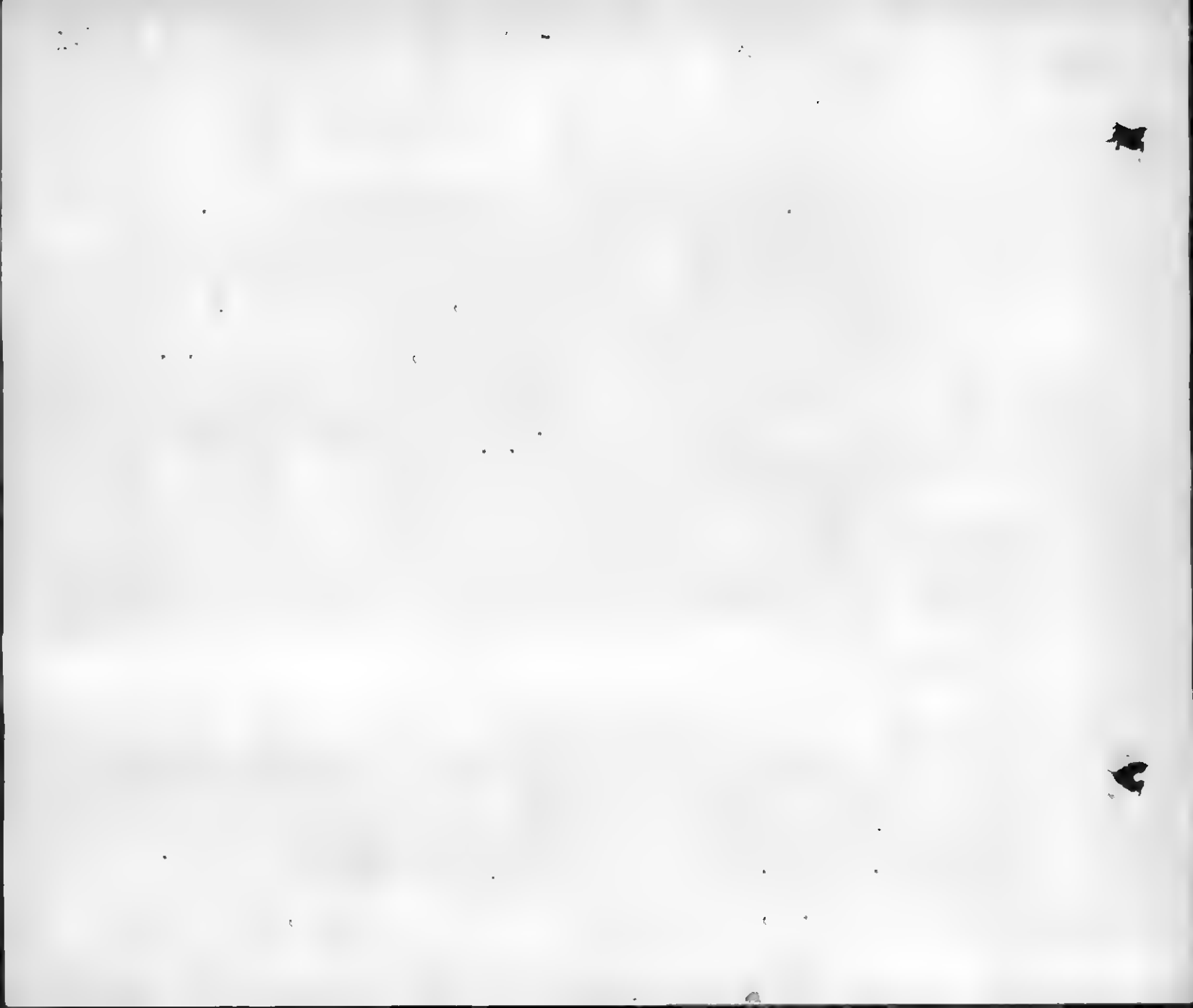


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FOR STATE  
HEALTH DEPT.

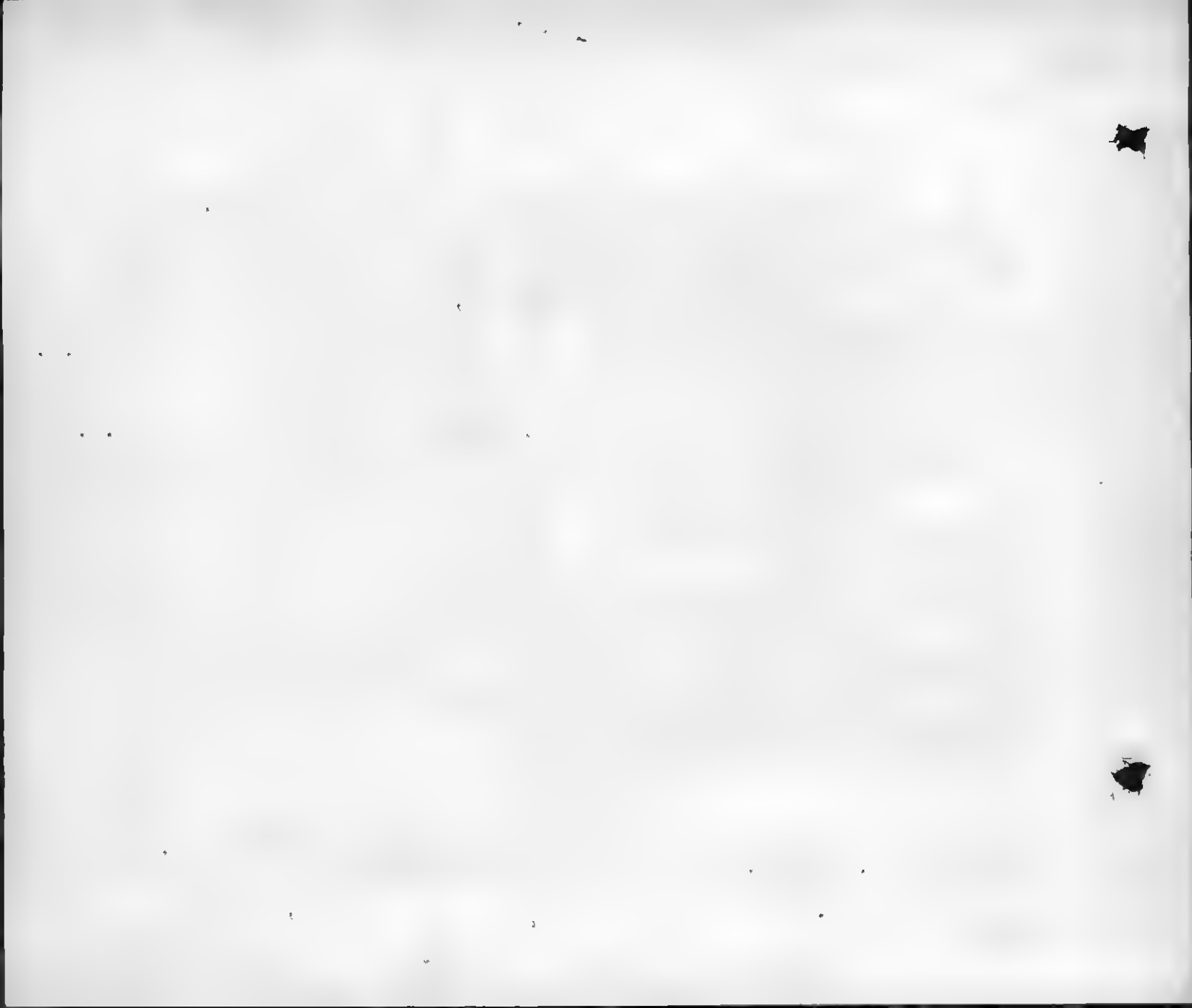
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 13122											
1. PLACE OF DEATH a COUNTY <b>Wicomico</b> <b>MARYLAND</b>						2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Wicomico</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				d. IS DECEASED ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pen Gen. Hospital</b>						d. STREET ADDRESS <b>712 Oak Hill Ave.</b>					
3. NAME OF DECEASED (Type or print) First <b>HELENA</b> Middle <b>WELITSCHKO</b> Last <b>WELITSCHKO</b>						4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>28</b> Year <b>1958</b>					
5 SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 30, 1908</b>		9. AGE (In years last birthday) <b>50</b> yrs		10. IF UNDER 1 YEAR: If UNDER 24 Hrs: <b>5</b> Days <b>27</b> Hours <b>Min</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Tonowka, Ukrain</b>				12. CITIZEN OF WHAT COUNTRY? <b>D.P. of Ukrain</b>	
13. FATHER'S NAME <b>Timofej Belimka</b>						14. MOTHER'S MAIDEN NAME <b>Natalia (Unk)</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Mr. Nickolaj Welitschko (Father-In-Law) R.D.# 2 Berlin, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Periferal circulatory failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Multiple fractures</b> DUE TO (c) <b>1 1/2 hrs.</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Passenger in car that ran off road and overturned</b>							
20c. TIME OF INJURY Month, Day, Year <b>11 PM 11-27-58</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Salisbury Wicomico Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Earl L. Royer</i> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>Nov. 30, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Berlin, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>						ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>DEC 3 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Earl L. Royer</i>	







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13112

## CERTIFICATE OF DEATH

13124

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>	
d. NAME OF HOSPITAL (If not hospital, give street address) OR INSTITUTION <u>Princess Anne General Hospital</u>		d. STREET ADDRESS <u>Cath Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>B</u> Last <u>Wherretts</u>		4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 20 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer for Electric Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Wherrett</u>		14. MOTHER'S MAIDEN NAME <u>Mary Louise Andrews</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Bertie Wherrett Princess Anne Md.</u>	
17. INFORMANT <u>Bertie Wherrett</u>		Address <u>Princess Anne Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Cor Pulmonale</u> DUE TO (b) <u>Bronchial Asthma</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease; Cerebral Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on 19 and that death occurred at 7:45 A.M. from the causes and on the date stated above			
ACTUAL SIGNATURE <u>David L. Latham</u> M.D.		DATE SIGNED <u>Nov 21, 1958</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/23/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Manokin Presbyterian</u>	22d. LOCATION (City, town, or county) (State) <u>Princess Anne Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Herman</u>		24. REC'D BY REGISTRAR <u>Nov 25 1958</u>	
ADDRESS <u>Princess Anne Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton L. Latham</u>	

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

131113 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13125

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Pen Gen. Hospital		STREET ADDRESS R.D.# 2	
3. NAME OF DECEASED (Type or print) First PRESTON Middle LEE Last WILKINS		4. DATE OF DEATH Month NOVEMBER Day 13th Year 58	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Mar. 28, 1910
9 AGE (In years last birthday) 48 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	11 BIRTHPLACE (State or foreign country) Powellville, Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farmer	12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Alison Wilkins		14. MOTHER'S MAIDEN NAME Mary Ellen Hales	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO INFORMANT Mrs. Stella M. Wilkins (Wife) R.D.# 2 Pittsville, Maryland	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		DATE SIGNED November 13 / 1958	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 16, 1958	22c. NAME OF CEMETERY OR CREMATORY Collins Family Cemetery-Worcester Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE C. L. H. H.	

THIS DEPUTY MEDICAL EXAMINER This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13114

CERTIFICATE OF DEATH

13126

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	c. LENGTH OF STAY IN 1b <b>1 yr. 28 da.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pondtown, Millington P.O. 17x-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>RFD 1</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>-</b> Last <b>Wilson</b>		4. DATE OF DEATH Month <b>November</b> Day <b>12,</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1892</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.	IF UNDER 24 HRS. Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Kent Co., Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Joe Woodland</b>	
14. MOTHER'S MAIDEN NAME <b>Isabelle Barrell</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>--</b>	
16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Deer's Head State Hospital Records, Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>Arteriosclerosis, general</b> DUE TO (c) <b>-</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>--</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>--</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. (City or town) (County) (State) <b>-</b>	
21. I certify that I attended the deceased from <b>Oct. 14, 1957</b> , to <b>Nov. 12, 1958</b> , that I last saw the deceased alive on <b>Nov. 12, 1958</b> , and that death occurred at <b>3:25 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>11/12/58</b> ACTUAL SIGNATURE <b>L. V. Maldve</b> M.D. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b> <b>Deer's Head State Hospital</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 17, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Union Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Rural Chestertown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward T. Holloway</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 19 58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kross</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF BIRTH _____		PLACE OF BIRTH _____		COUNTY _____	
DATE OF DEATH _____		PLACE OF DEATH _____		COUNTY _____	
TIME OF DEATH _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF REGISTRAR _____		SIGNATURE OF WITNESS _____	
PRINTED NAME OF PHYSICIAN _____		PRINTED NAME OF REGISTRAR _____		PRINTED NAME OF WITNESS _____	
ADDRESS OF PHYSICIAN _____		ADDRESS OF REGISTRAR _____		ADDRESS OF WITNESS _____	
CITY _____		CITY _____		CITY _____	
STATE _____		STATE _____		STATE _____	
COUNTY _____		COUNTY _____		COUNTY _____	
ZIP CODE _____		ZIP CODE _____		ZIP CODE _____	

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13115**  
**CERTIFICATE OF DEATH**

Reg. Dist. No. **13127**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Wicomico</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u> d. STREET ADDRESS <u>Locust Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Alberta</u> <span style="float: right;">First</span> <u>Wright</u> <span style="float: right;">Middle</span> <u>Wright</u> <span style="float: right;">Last</span>			<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>5</u> Year <u>19 58</u>				
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>11, 25, 1926</u>		<b>9. AGE</b> (In years last birthday) <u>31</u> yrs. Months Days Hours Min.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>					
<b>13. FATHER'S NAME</b> <u>Colburn Wright</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Cropper</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>no</u>		<b>17. INFORMANT</b> <u>Georgia Deal Fruitland Maryland</u> <span style="float: right;">Address</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Rheumatic Valvulitis - insufficing</u> <u>401.0</u> DUE TO (b) <u>Pericarditis; cirrhosis of liver - congestion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>of lungs + liver.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that I attended the deceased from</b> <u>10/12</u> , 19 <u>58</u> , to <u>11/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/5</u> , 19 <u>58</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.					
<b>ACTUAL SIGNATURE</b> <u>A.C. Mitchell</u>		<b>ADDRESS</b> (Street, city or town, state) <u>211 Maryland Ave., Salisbury, Md.</u> <b>DATE SIGNED</b> <u>11/11/58</u>					
<b>PHYSICIAN'S NAME</b> (Type) <u>A.C. Mitchell, M.D.</u>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>11/9/58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Calvary</u>			
<b>22d. LOCATION</b> (City, town, or county) (State) <u>Fruitland Maryland</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Clinton E. Stewart, Salisbury Md</u>					
<b>24a. REC'D BY REGISTRAR</b> <u>NOV 12 '58</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanna</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1917

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

PLACE: \_\_\_\_\_

CAUSE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_